A mapping exercise: making the case for public investment in health

TSI2022/MCP/164: Resources hub for sustainable investment in health

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Report

A mapping exercise: making the case for public investment in health

TSI2022/MCP/164: Resources hub for sustainable investment in health

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List of abbreviations

ACT UP	AIDS Coalition to Unleash Power
CBA	Cost-benefit analysis
CMS	Centers for Medicare & Medicaid
DG REFORM	Directorate-General for Structural Reform Support
DRG	Diagnosis-related group
EHIS	European Health Interview Survey
EU	European Union
GDP	Gross domestic product
HIA	Health impact assessment
HiTs	Health System in Transition series
HSPA	Health system performance assessment
HTA	Health technology assessment
MHH	Menstrual health and hygiene
NHS	National Health Service
NGO	Non-governmental organization
OECD	Organization for Economic Cooperation and Development
OOP	Out-of-pocket
PaRIS	Patient reported indicator surveys
PASH	Population Ageing financial Sustainability gap for Health systems
PREM	Patient reported experience measures
QALY	Quality-adjusted life year
SILC	Statistics on Income and Living Conditions
TSI	Technical Support Instrument
UHC	Universal health coverage
WHO	World Health Organization

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Disclaimer

This report provides an overview of the types of arguments, tools, data and indicators that can be used to make the case for investment in health. It is not meant to be a formula or a step-by-step instruction kit for building a budget case, but rather it serves as a practical starting point for thinking about the different arguments, tools, data, framing and resources that can be used to convince policy makers to invest more and smarter in health. The lists and case studies included in the report provide some important examples, but they are not exhaustive. Thus there are undoubtably approaches, tools, indicators and/or datasets which have not been named in this report but can still play an important role in making the case for public investments in health.

Key messages

- **Across the European Union, while public budgets are facing pressures, many policy makers are becoming increasingly concerned about how to adequately and sustainably fund their health systems to keep up with need and demand.** There are a variety of upwards pressures on health spending and a growing need to make the case for adequate public funding for the health system. As countries move beyond having to manage the COVID-19 pandemic it is important to rethink how health stakeholders can communicate with public budget holders and work to ensure sustainable public resourcing for health.
- **Budget cases for public funds for health tend to be most successful when they align well with the goals and objectives of public finance stakeholders.** Some arguments that can foster this alignment include that investments in health: address health needs and improve health; have co-benefits beyond health; can be sustainable; can be used efficiently; and/or are important to the public. Certain tools, data and indicators can support these arguments.
- **While data and evidence are important for successfully making the case for public investment in health, they are insufficient on their own.** Enablers for successful negotiation often include: robust evidence and data analysis capacity; clear health priorities; stakeholder engagement; effective communication; identifiable economic and social benefits; advocacy and engagement with civil society; regional and international comparisons; and evaluation and learning.
- **Data and evidence can help steer decision makers to make good choices (or at least avoid bad ones), but other factors (e.g. political will, engagement and cooperation, transparency and trust) are the fuel to push the budget case for health forward successfully.** In many health systems, the majority of health budgets are determined fairly automatically by formulas, but there is still some scope for negotiation for additional investment in health at the margins.
- **One important way of successfully making the case for increased investment in health is to quickly recognize and capitalize on windows of opportunity when they arise.**
- While the mapping exercise and this resulting report serve as a starting point resource to help stakeholders begin to navigate the complexities of building and supporting a case for additional public financing for health, ultimately **each budget case for health should be framed with a narrative that meets the objectives, goals and contexts of those that they are being pitched to, and thus will be bespoke.**

Executive summary

As health systems face increasing budgetary pressures, there is a growing need to strengthen capacity to make the case for greater public investment in health.

Demands on health systems are rising with the growing burdens of chronic disease, the introduction of expensive new technologies, demographic changes, etc. Meanwhile, public budgets face many competing demands for high priority expenditure and have limited scope to fund spending from borrowing. COVID-19 exposed the consequences of historical underinvestment in many health care systems, and as countries move beyond managing the pandemic, it is crucial that they avoid repeating the same mistakes and ensure that health systems are supported by sufficient public funding.

However, those making the case for greater public investment in health are often met with doubts and counter-arguments. Health policy makers increasingly find themselves needing to build capacity to better communicate and negotiate for increased public funding for health.

To explore approaches and tools for making the case for public investment in health, a mapping exercise was conducted as part of a larger project.

In recognition of these challenges, in September 2022 a Technical Support Instrument (TSI) project funded by the Directorate-General for Structural Reform Support (DG REFORM) was launched together with three European Union (EU) Member States – Austria, Belgium, and Slovenia – with the goal of strengthening capacity to make the case for public investments in health. To support these efforts, beginning in January 2023 the European Observatory on Health Systems and Policies conducted an exercise to map relevant analytical approaches and tools for making the case for public investment in health. The following report describes the findings of this exercise in a simple and easily accessible manner.

A framework of arguments and selected tools, data, indicators and methods can be used to help support the case for public investment in health.

A key result of this exercise and report was the establishment of a framework that has been designed to support health policy makers, advisors and advocates by providing five key lines of argument and selected examples of tools, data, indicators and methods that can be used to successfully make the case for public funding for health. These arguments, tools, data and indicators address common concerns that decision makers have around investments in health and satisfy four key public financial management objectives (demonstrating good stewardship of public resources, supporting societal well-being, ensuring fiscal sustainability, and promoting macroeconomic growth). They can be used to build trust and alignment between health and finance stakeholders. These arguments (which naturally cut across, overlap and build on one another) include that health system investments:

- address health needs and improve health
- have co-benefits
- can promote sustainability
- can be used efficiently and effectively
- are important to the public.

Evidence, data and indicators are important, but they are often insufficient on their own for successful budget negotiations.

While the evidence, tools, data and indicators highlighted in the report play a key role in successfully negotiating for funding for health, they only make up one piece of the puzzle. Many of the experts in stakeholder interviews expressed the view that building convincing cases for additional investment in health hinges on several other factors. Important enablers of successfully advocating for health financing include: data analysis capacity to effectively model and present the evidence; having clear priorities which can be aligned with those of finance stakeholders; effectively communicating and creating a compelling narrative around the budget case; actively engaging with governmental stakeholders, civil society groups and other non-governmental actors to build understanding and consensus; and evaluating and learning from previous experiences with health investments to continually improve. While data and evidence can help steer decision makers towards good choices, other factors (including cooperation, communication, transparency, accountability and trust) provide the fuel that pushes the budget case for health forward effectively and successfully.

Interviewees also stressed the importance of identifying windows of opportunity in the negotiation process. Further, they highlighted how certain institutional arrangements can help with quickly recognizing and capitalizing on these windows of opportunity as soon as they arise. Successfully harnessing these crucial moments often also requires creativity and flexibility to adapt budget narratives to meet contexts appropriately.

The results from this exercise serve as a starting point resource, but ultimately each budget case for health will be unique to fit needs, preferences and context.

The mapping exercise and its resulting report serve as a starting point resource to help health stakeholders consider opportunities to strengthen their investment cases for public funding for health. It provides a comprehensive (but non-exhaustive) list of tools, data and indicators that can be used to make the case for investment in health, with details on how these can be framed most effectively. However, this report is not meant to serve as a step-by-step instruction manual. Ultimately, a budget case for health should entail a narrative and evidence to match the objectives and goals of those it is being pitched to, and thus each one will be unique.

1. Background

1.1 Resources are becoming increasingly scarce, but health needs are rising

Health systems face major sustainability challenges. The COVID-19 pandemic led countries to increase their fiscal deficits in order to respond appropriately to the crisis at hand; but as countries move beyond managing the COVID-19 pandemic, they are considering ways to reduce these deficits. The threat of austerity measures which will cut social spending looms (Public Services International, 2019). This comes on top of long-standing debates over how to sustainably finance health care.

Before the pandemic, total health spending had often outpaced gross domestic product (GDP) growth across Organization for Economic and Development (OECD) countries. Projections suggest this will continue to at least 2030 (OECD, 2019b). European countries are grappling with growing demand for health care services as the burden of chronic diseases rises, costly technological innovations are introduced, population demographics shift, etc. Chronic conditions such as hypertension, diabetes and cardiovascular disease already account for 80% of the disease burden in European countries (Eurostat, 2020). People with chronic conditions typically use health care services frequently and often require complex, expensive treatment (Maynou, Street & García–Altés, 2023). Furthermore, chronic conditions can reduce labour productivity and increase rates of absenteeism (or lead people to leave the workforce altogether), thus reducing tax revenues and ultimately lowering returns on human capital investment (Hofmarcher et al., 2020; European Commission, 2023). As technologies improve, people are living longer, leading European societies to age rapidly. Older people – who typically have higher average health care expenditure than younger people – are more likely to have chronic diseases and multimorbidity, and so there are worries that a larger older population will put additional pressure on public health care financing (Eurostat, 2020). Health systems also face many other challenges beyond these, such as climate change emergencies, violent conflict, and others.

1.2 The performance and long-term sustainability of health care systems, and ultimately population health outcomes, are under threat

The consequences of insufficient public spending on health have been extensively documented and shown to negatively impact health care affordability, availability and accessibility. For instance, in some places low government spending on health has led to shortages of health care workers, causing staff to be overburdened and resulting in lower quality care (WHO Regional Office for Europe, 2021). In addition, austerity measures and resulting reductions in health budgets may lead to shortcomings in care coverage and the introduction of or increased reliance on user fees and out-of-pocket (OOP) spending for health services and pharmaceuticals. These additions in turn may reduce individuals' financial protection and increase their incidence of catastrophic health expenditure and unmet need for care in the long run (Karanikolos et al., 2013; Public Services International, 2019; WHO Regional Office for Europe, 2023). Lower-income populations are particularly vulnerable to the implications of austerity policies, as they may face greater challenges in affording and accessing care privately, thus exacerbating existing health inequalities.

It is worth noting that simply shifting from public to private financing does not improve the affordability of health care. In fact, the guiding principles of health financing of the World Health Organization (WHO) encourage movement towards public funding as the predominant financing source, and reducing fragmentation in the pooling of funds (WHO, no date). Furthermore, studies find that relying on private health funding as a predominant source of financing can undermine equity and access in the health system (Johnston et al., 2019). As a result, this report focuses on public financing of health care.

1.3 The COVID-19 pandemic exposed the risks and dangers of inadequate investment in health systems

COVID-19 placed immense pressure on health systems and exposed the consequences of historical underinvestment and misallocated investment in health care, especially in the health care workforce, hospitals, primary care, social care and mental health. Despite decades of warnings about underinvestment, many health systems were not equipped with the resources, capacity, flexibility or resiliency to deliver health services adequately and equitably when crisis hit (European Observatory on Health Systems and Policies, 2021c). Those which had not adequately resourced and built up their public health systems before the COVID-19 pandemic had to rely on hospitals at the frontline of the crisis. Not only did this have consequences for morbidity and mortality due to COVID-19, but also that associated with other pathologies due to displacement of care capacity away from other health care services. The pandemic also demonstrated that public health care financing not only has implications for population health outcomes, but also for societal outcomes more broadly (including education, tourism, hospitality, labour, etc.). It reinforced just how important universal health coverage (UHC) is for societies in responding to, coping with and recovering from crises.

As countries move beyond the pandemic, there are opportunities to rethink how health and finance stakeholders can work together to ensure sustainable public resourcing of health care. ***With this goal in mind, it is critical to understand – based on the evidence – how best to frame and support the case for more and better-utilized public investment in health in ways that achieve policy maker objectives across multiple sectors*** (Pan-European Commission on Health and Sustainable Development, 2021).

2. Introduction

2.1 Why is it so difficult to make the case for health systems?

Given a backdrop of limited choices for funding public spending and increasing pressures on those funds, governments must allocate sufficient and sustainable levels of resources to health systems, and these investments should be directed in ways which achieve value for money. In any country, a variety of factors will influence public spending decisions on health. These may include epidemiology; medical need, demand and supply; and social norms and preferences (Cylus, Permanand & Smith, 2018). Yet there is widespread variation in overall health spending between countries with similar circumstances, suggesting that decisions around health spending are often heavily influenced by political factors (as is most public sector spending) (Forman, Permanand & Cylus, 2024).

2.1.1 Those making the case for public funding of health are often faced with concerns and misperceptions about health system investments

Some economists and financial decision makers may be hesitant about investing in health systems. There is a commonly held misbelief among this population that health systems do not support – or may even undermine – economic and fiscal objectives, and that they represent an unproductive drain on the economy. This is driven by the view that the health sector consumes a disproportionate share of national resources while delivering limited measurable returns compared to those in other sectors.

Cylus, Permanand and Smith identified five specific concerns decision makers may have around health system investments:

1. whether health systems consume more national capital than is optimal;
2. whether extra spending on health really contributes marked improvements to health, or if more could be achieved by investing in other sectors;
3. whether health systems are capable of using increased funding efficiently, or if the risk of corruption, waste, mismanagement or misallocation of resources is too great;
4. whether there is scope for productivity growth in health services; and
5. whether public investments in health are really going towards healthier living, or just longer living (Cylus, Permanand & Smith, 2018).

When entering negotiations for health funding, it is important that these concerns are understood, considered and acknowledged, and that evidence is supplied to support counterarguments. Budget cases for health should be framed in a way that meets the policy and financial objectives of those they are being pitched to, and that minimizes these concerns (or even prevents them from arising in the first place).

Crucially, this means that each investment case for health will be unique: it will be based on the concerns, objectives and preferences of the stakeholders and decision makers involved, the particular context within which these budgets are being determined, and the available evidence and analytical capacity to support the case.

2.2 Health systems must demonstrate the value and benefits of additional spending for health and beyond

With health systems competing against other sectors for public financing, ministry of health representatives and other health policy stakeholders must be equipped with the knowledge, data, tools, language and rationales to effectively advocate for investments in health. To do this, not only do health stakeholders need to demonstrate the value of health systems, policies and initiatives in terms of maintaining and improving population health outcomes, but they also need to demonstrate the wider value and benefits of health, and thereby make a compelling case for how health and health systems meet the economic, fiscal and social objectives of those in charge of public expenditure (Cylus, Permanand & Smith, 2018; World Bank, 2018; Greer et al., 2023).

As will be discussed further in section 5, the health system has both direct and indirect impacts on societal wellbeing. Fig. 1 summarizes this relationship.

Examples of direct impacts of the health system on wealth include employment of a large workforce and medical research and development (arrow 3). Indirect impacts of the health system on wealth are achieved through improved health (arrow 1). These impacts of the health system then have direct and indirect influences on labour productivity, educational attainment, financial savings, etc. (arrow 2), as described by Cylus, Permanand and Smith:

> The increased longevity and reduction in disability secured by the health system can feed through to the macroeconomy via a multitude of unexpected routes, such as reduced absence from work due to ill health, increased retirement age, increased investment in human capital caused by expectations of a longer working life, and increased demand for savings which in the long run may give rise to greater capital investment. (Cylus, Permanand & Smith, 2018:10)

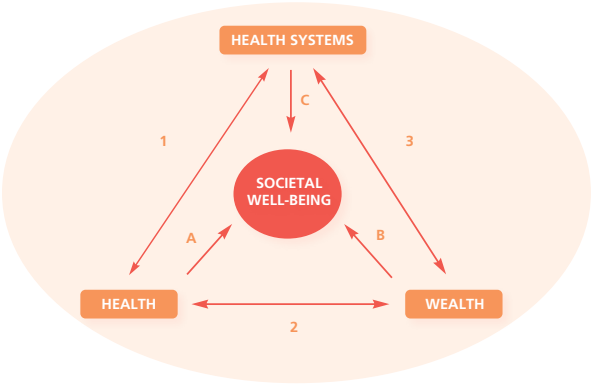
The security and protection offered by health systems (arrow C), improved health (arrow A), and the wealth generated by health directly and indirectly (arrow B), all then contribute to societal wellbeing.

While this makes intuitive sense, methodological challenges (often introduced because of the interdisciplinary relationship between health and other sectors) can make it difficult to measure and quantify the full impacts of health funding and interventions on sectors beyond health. Still, there are some ways to tackle these barriers and to make evidence-based arguments around the co-benefits for other aspects of societal wellbeing that additional spending on health brings (see section 5.2).

2.3 Mapping different approaches, tools, data and indicators for making the case for public investments in health

Beginning in September 2022, a project funded by the Directorate-General for Structural Reform Support (DG REFORM) of the European Commission was launched together with three EU Member States – Austria, Belgium and Slovenia – to strengthen capacity for making the case for public investment in health at the national and international level (workstream 1 of the project), and to use EU funding mechanisms in more effective and efficient ways (workstream 2 of the project). The project came about after the three Members States requested this support in accordance with the criteria and principles referred to in Article 9

Figure 1 **Cylus, Permanand and Smith's representation of the triangular relationship between health systems, health, wealth and societal wellbeing**



Source: Reprinted from Cylus, Permanand & Smith, 2018.

of the Technical Support Instrument (TSI) Regulation. The European Commission assessed and decided to fund the request.

Starting in January 2023, the European Observatory on Health Systems and Policies (hereafter referred to as the European Observatory) supported workstream 1 by mapping relevant analytical approaches and tools for making the case for public investment in health in the three Member States and internationally. As detailed in Box 1, the methods for this exercise included two main components: (1) a literature review, and (2) interviews with key experts. The literature review served as an initial exploration of the approaches, tools, data and indicators that can be used by health stakeholders and advocates to articulate, promote and highlight the significance and value of health systems. Subsequently, 16 interview sessions with a total of 25 experts were conducted to understand the context in which these budget negotiations take place, and how or whether the approaches, tools, data and indicators identified through the literature review work in practice.

This report aims to support health policy makers, advisors and advocates by: (1) providing a framework which maps selected examples of evidence, arguments and tools used at national and international levels to make the case for public investment in health, and (2) shedding light on how these currently work in practice and describing the opportunities for using and improving these in future.

Box 1 **Methods used for mapping exercise**

A literature review was employed to identify key arguments, approaches, data, indicators and tools used to advocate for increased investment in health systems in the three Member States and internationally. Peer reviewed articles sourced from Google Scholar, PubMed and Scopus, as well as white papers published by institutions such as WHO and the European Observatory, were examined. The overarching goal of the review was to identify best practice and supporting data and tools that are commonly used to develop compelling cases for increased and improved investment in health. To generate an array of approaches, tools, data and indicators, the review extended beyond the three Member States so that valuable lessons from other countries were incorporated in the findings. Evidence from high-income countries was reviewed, with a specific emphasis on those in the EU.

With the initial results from the literature review, semi-structured expert interviews were conducted to better understand: (1) the context in which budget negotiations take place, (2) the role of evidence in these decision-making practices, and (3) the successes, challenges and opportunities from using the arguments, tools, data and indicators which were identified in the literature review. Interviews were conducted via Zoom with one to three interviewers present (one interviewer attended all interviews for consistency). Most interviews (10) were held with a single interviewee; however, in several cases multiple interviewees joined a single discussion. A variety of stakeholders were consulted, including from finance (e.g. ministry of finance) and health backgrounds (including ministry of health and health insurance fund stakeholders), those from the three Member States and other EU countries, and those working at the national and regional levels. A list of questions was developed as a general tool to guide the discussions rather than as a strict script which all interviews followed. This allowed flexibility so that the interviews could focus on specific relevant case studies or shift to be more appropriate to the expertise of the stakeholder(s) involved.

3 Linking arguments and tools with economic, financial and societal objectives to make a successful case for public investment in health

3.1 An organizing framework for the mapping exercise

To organize our findings from the literature review, we considered what had already been learned from existing frameworks for discussing government health expenditure decisions. The Cylus, Permanand and Smith (2018) framework in Fig. 1 acknowledges that ministries of finance hold significant power in determining public expenditure decisions and economic policies. It highlights themes that are commonly found in ministry of finance mission statements across the European Region. These include: (1) demonstrating good stewardship of public resources, (2) promoting macroeconomic growth, (3) supporting societal wellbeing, and (4) ensuring fiscal sustainability. As mentioned above, the Cylus, Permanand and Smith (2018) framework also highlights common concerns finance stakeholders have around investing public funds in health, and potential counterarguments to these.

In the initial phases of the mapping exercise, we began to align the common concerns around investment in health and their counterarguments as outlined by Cylus, Permanand and Smith (2018) with the indicators, tools and approaches emerging from the literature review. Together, these themes, concerns and counterarguments served as a starting point to structure evidence and tools which health stakeholders can use to support arguments for health care investment and ways to approach budget negotiation processes.

We then took this a step further and built upon Cylus, Permanand and Smith's 2018 work to identify five key arguments in favour of additional investment in health systems. For each argument, we describe a selected set of tools, data and indicators which can be used in support. Fig. 2 demonstrates this framework, mapping the relationship between the arguments, tools, data and indicators that can be used to make the case for public investment in health and how they meet the key objectives of finance stakeholders.

In the following section, we detail each argument, along with examples of tools and indicators which can be used to support them. Further, we describe how these can be used to build a compelling narrative that increased funding for health is needed and that investing in health is a smart choice for decision makers.

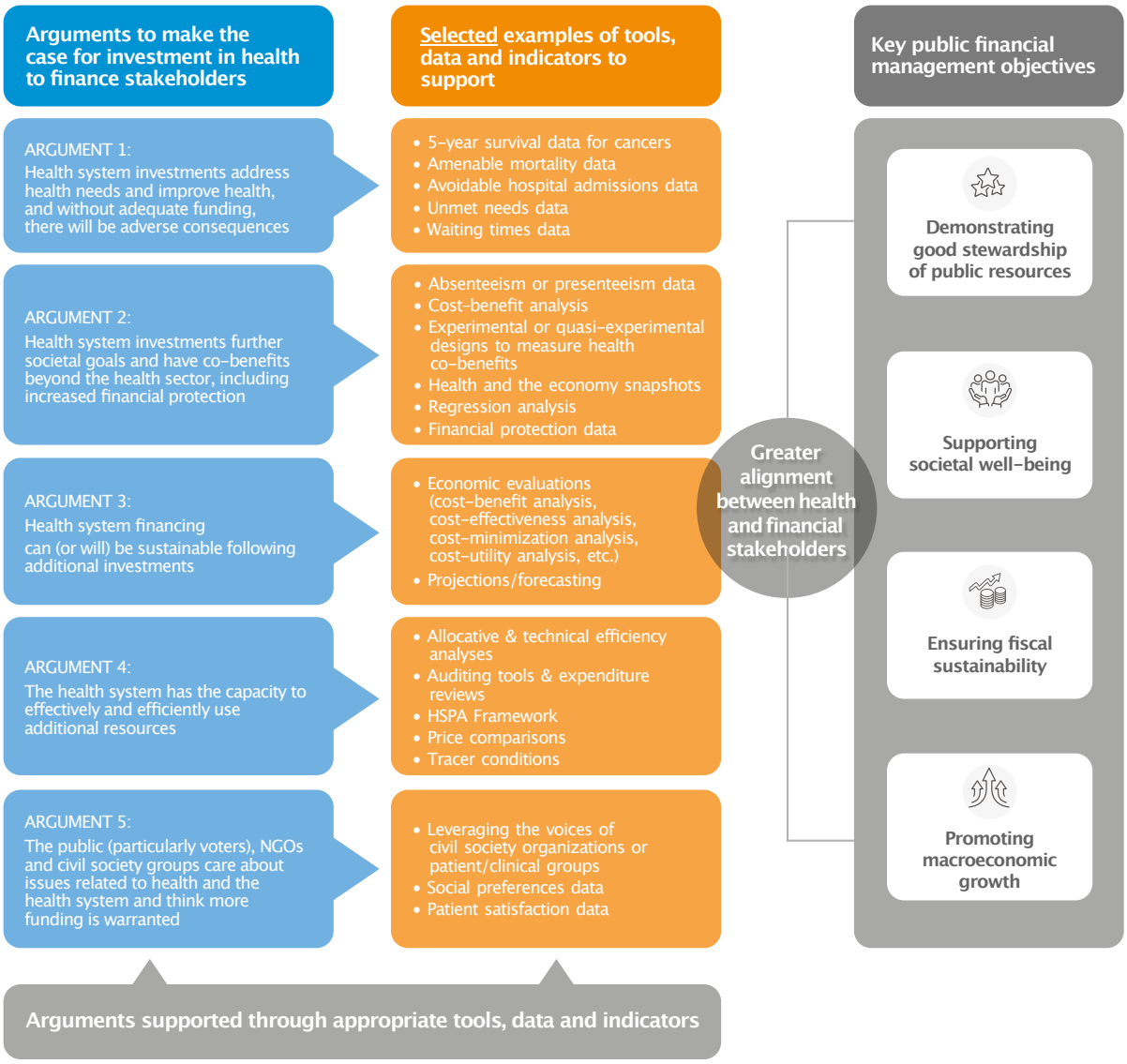
3.2 Five key arguments and their associated tools to make the case for investments in health

Five key arguments can be used to make the case for public investment in health:

1. Health system investments address health needs and improve health, and without adequate funding, there will be adverse consequences.
2. Health system investments further societal goals and have co-benefits beyond the health sector, including increased financial protection.
3. Health system financing can (or will) be sustainable following additional investments.
4. The health system has the capacity to effectively and efficiently use additional resources.
5. The public (particularly voters), non-governmental organizations (NGOs) and civil society groups care about issues related to health and the health system and think more funding is warranted.

The above arguments can also be made as counterfactuals/with a negative framing. For example, Argument 2 can be framed as: a lack of adequate levels of public funding for health does not just have consequences for the health system; it also has

Figure 2 **Organizing framework mapping arguments and tools to make the case for public investments in health**



consequences beyond the health sector (including economic ones).

These five arguments, of course, overlap and are interrelated. For example, arguments around health system investments being used to address health needs and improve health (Argument 1) will often hinge on the effectiveness and efficiency of the system (Argument 4), and this, in turn, will link to sustainability (Argument 3). Similarly, individual tools, data and indicators may be used to support multiple lines of argument. For example, data on waiting times may be used to demonstrate where investments in health could achieve large improvements in accessibility (Argument 1), or they may be used to show that waiting times are an important policy issue and have a direct impact on civil society groups and the public – particularly voters (Argument 5). Furthermore, long waiting times have consequences which can reduce efficiency outcomes (e.g. delays to cataract surgery may reduce years of sight gained per operation) (Argument 4). The arguments in the framework should not necessarily be treated as separate entities, but rather as interweaving parts that form a complete and compelling case for why additional and better public spending for health is needed.

Each of the five arguments can be supported by tools, data and indicators to help policy makers make more effective investment cases for health. In the following sections, we consider how selected examples of data, tools and models can build and support the narrative that greater investment in health is needed. It is important to acknowledge, however,

that budget negotiations for health funding are unique and context-specific, and as such, that there is not a one-size-fits-all approach or formula for convincing financial policy stakeholders to invest more in health. Different countries and different health stakeholders have different needs, preferences and constraints. They advocate in favour of different investments in particular policy areas (e.g. digitalization, primary health care, etc.), each of which has its own nuanced arguments and evidence which supports additional expenditure.

Rather than providing a specific recipe to better support policy makers in making the case for public investments in health, the five arguments and the selected examples of tools and evidence serve as a non-exhaustive menu of potential options for framing a case for additional and better spending on health. These approaches will inform subsequent phases of the TSI project (see Box 2).

Box 2 **How the mapping activity fits into the TSI project**

The framework in this paper is intended to serve as a starting point for the types of arguments, tools and indicators that can be used to build a compelling case for public investment in health. As such, the mapping activity (part of output 1.1) served to inform the subsequent phase of the TSI project (output 1.2) in which suitable analytical approaches and tools for making the case for public investment in health in each of the three Member States were explored and selected.

Workstream 1 outputs and activities:

- Output 1.1: Report and supporting activities on existing relevant analytical approaches and tools at national and international level for making the case for public investment in health and for defining the specific needs of the three Member States' health authorities
  - Activity 1.1.1 Mapping of relevant analytical approaches & tools in the 3 Member States for making the case for public investment in health
  - Activity 1.1.2 Mapping of relevant analytical approaches & tools at the international level for making the case for public investment in health
  - Activity 1.1.3 Organization of a workshop on international good practices for making the case for public investment in health
- Output 1.2: Suitable analytical approaches and tools per Member State for making the case for public investment in health
  - Activity 1.2.1 Country-specific needs analysis and selection of approaches & tools for voluntary piloting
  - Activity 1.2.2 Country-specific adaptation of the selected approaches & tools and elaboration of country-specific action plans for their implementation as pilot
- Output 1.3: Implementation plan per Member State to integrate the selected approaches and tools in the Ministries of Health and other relevant authorities' strategic work plans
  - Activity 1.3.1 Capacity building and country-specific support for voluntary piloting of approaches and tools
  - Activity 1.3.2 Institutionalization of analytical approaches & tools and elaboration of a guide/toolkit for their potential long-term use

4. One-page summaries of the arguments to support making the case

The five arguments are summarized on the following pages, along with how each one can be used to make the practical case for public investment in health. The summaries outline how each argument meets financial objectives and addresses common concerns around public investment decisions, and highlight examples of the tools, data and indicators that can be used to support the arguments. Further detail is provided in section 5.

ARGUMENT 1: **HEALTH SYSTEM INVESTMENTS ADDRESS HEALTH NEEDS AND IMPROVE HEALTH, AND WITHOUT ADEQUATE FUNDING, THERE WILL BE ADVERSE CONSEQUENCES**

OBJECTIVES

This argument demonstrates that spending on health meets both needs and demand, and thus contributes to population health and wellbeing. This argument can also be used to show that without adequate funding, there will be adverse consequences to health care access, affordability and/or quality, and therefore to population health and wellbeing outcomes more broadly.

FINANCE POLICY GOAL(S) IT CONSIDERS:

- Demonstrating good stewardship of public resources
- Supporting societal wellbeing

ADDRESSES COMMON CONCERNS AROUND INVESTING PUBLIC FUNDS IN HEALTH BY:

- Demonstrating public spending on health makes a meaningful contribution to health improvements

OVERVIEW

Naturally, the main objective of the health system is to address health needs and improve population health. One of the main and perhaps most frequently used arguments for additional investments in health is simply that health systems need more resources to maintain and improve population health outcomes, and that without more funding, there will be adverse consequences. This may be especially compelling given demographic shifts and price increases for health services as inflation climbs and expensive innovations and medicines are released on to the market.

HOW DOES THIS ARGUMENT HELP MAKE THE CASE FOR INVESTMENT?

Improved health outcomes are not in and of themselves primary objectives of finance policymakers, but it is important for them to see that public finances are contributing to a good standard of living overall, and that resources are being used well. Thus it is beneficial to demonstrate that spending on health achieves its intended objectives and contributes to population health. Using data, indicators and tools, health systems can show that public financing of health directly contributes to better health and wellbeing outcomes, and reduced morbidity and mortality.

SELECTED EXAMPLES OF TOOLS, DATA AND INDICATORS TO SUPPORT THE ARGUMENT

- 5-year survival data for cancers, etc.
- Amenable mortality data
- Avoidable hospital admissions data (e.g. to advocate for primary care funding)
- Unmet needs data
- Waiting times data

ARGUMENT 2: **HEALTH SYSTEM INVESTMENTS FURTHER SOCIETAL GOALS AND HAVE CO-BENEFITS BEYOND THE HEALTH SECTOR, INCLUDING INCREASED FINANCIAL PROTECTION**

OBJECTIVES

This argument demonstrates that not only do well-functioning, well-funded health systems produce good health outcomes, but they also play a crucial role in the broader economy and have direct and indirect co-benefits for other aspects of societal wellbeing, including financial protection. This shows how investment in health is also an investment in the economy, education, social equity and beyond.

FINANCE POLICY GOAL(S) IT CONSIDERS:

- Demonstrating good stewardship of public resources
- Supporting societal wellbeing
- Promoting macroeconomic growth

ADDRESSES COMMON CONCERNS AROUND INVESTING PUBLIC FUNDS IN HEALTH BY:

- Demonstrating that health contributes to gains beyond the health sector (including economic gains and benefits for the labour market)
- Demonstrating how health contributes to human capital, wealth and societal wellbeing at all ages (including through improved financial protection)

OVERVIEW

Health has co-benefits beyond the health sector, and health systems directly and indirectly contribute to societal wellbeing. For example, improvements in population health outcomes can lead to greater, longer and more productive participation in the workforce, better education enrolment and attendance rates, improved gender equity, greater financial protection, etc.

HOW DOES THIS ARGUMENT HELP MAKE THE CASE FOR INVESTMENT?

The argument that an investment in health is also an investment in the economy, in education and in the social sector aligns with several public finance objectives and is a valuable framing lens in negotiations between health and finance stakeholders. Thus it is beneficial to demonstrate and quantify how spending on health has co-benefits beyond the health sector. This is especially salient as shifting demographics place increasing pressures on economies. For example, demonstrating that economic slowdowns due to an ageing population may be avoidable if there is increased funding to support healthy and active ageing may be a particularly convincing argument for finance stakeholders looking for ways to boost the economy.

SELECTED EXAMPLES OF TOOLS, DATA AND INDICATORS TO SUPPORT THE ARGUMENT

- Catastrophic health expenditure data
- Cost-benefit analysis
- Data on absenteeism
- Data on presenteeism
- Experimental designs
- Health and the economy snapshots
- Quasi-experimental designs
- Regression analysis
- Financial protection data

ARGUMENT 3: **HEALTH SYSTEM FINANCING CAN (OR WILL) BE SUSTAINABLE FOLLOWING ADDITIONAL INVESTMENTS**

OBJECTIVES

This argument demonstrates that additional spending is likely to lead to greater financial sustainability. Particularly in health systems that are systematically underfunded, this argument can show that investing more in the health sector presents the opportunity to adopt more efficient processes (linked to Argument 4), and therefore produce a greater return on investment than an underfunded system (linked to Arguments 1 and 2).

FINANCE POLICY GOAL(S) IT CONSIDERS:

- Demonstrating good stewardship of public resources
- Ensuring fiscal sustainability

ADDRESSES COMMON CONCERNS AROUND INVESTING PUBLIC FUNDS IN HEALTH BY:

- Demonstrating that health spending does not automatically beget more health spending

OVERVIEW

A sustainable health financing system generates sufficient revenues to continue financing the health system inputs. If directed toward appropriate areas, funding for health can be seen as an investment that improves the functioning of the health system (and may even lead systems to be able to release resources towards other areas), rather than a cost with limited additional gain.

HOW DOES THIS ARGUMENT HELP MAKE THE CASE FOR INVESTMENT?

This argument can be used to advocate for investments in areas which will improve health system functioning in the medium to long term, and can help decelerate health expenditure growth. If funding for health is treated as an investment with potential for improving health system functioning so that resources can be released elsewhere over time, rather than a cost with limited additional gain, it may be easier to convince budget holders to release additional funds. If this argument is made successfully with robust evidence, this can help appease a common concern among those making public financing decisions: that spending begets spending. This argument and the tools, data and indicators to support it can serve as a useful way to speak a common language with finance stakeholders.

SELECTED EXAMPLES OF TOOLS, DATA AND INDICATORS TO SUPPORT THE ARGUMENT

- Economic evaluations: cost-benefit analysis, cost-effectiveness analysis, cost-minimization analysis, cost-utility analysis, etc.
- Projections and forecasting models (e.g. Population Ageing financial Sustainability gap for Health systems [PASH] Simulator)

ARGUMENT 4: THE HEALTH SYSTEM HAS THE CAPACITY TO EFFECTIVELY AND EFFICIENTLY USE ADDITIONAL RESOURCES

OBJECTIVES

This argument can be used either to demonstrate that a health system is already a good steward of its resources and thus will be able to absorb new monies without waste, or to show that more public funding is needed to achieve greater efficiency in the health system.

FINANCE POLICY GOAL(S) IT CONSIDERS:

- Demonstrating good stewardship of public resources
- Ensuring fiscal sustainability
- Supporting societal wellbeing

ADDRESSES COMMON CONCERNS AROUND INVESTING PUBLIC FUNDS IN HEALTH BY:

- Demonstrating that health systems consume a socially optimal level of public funding, or will do so with additional investment
- Demonstrating that health systems are increasingly identifying and monitoring the sources of inefficiencies and working to remedy any waste, corruption or misallocation of resources

OVERVIEW

This argument can be used to help convince budget holders either that additional funding for health will be used well and contribute to societal wellbeing and fiscal sustainability, or that increased financing for health will improve the efficiency of aspects of the health system that have traditionally underperformed.

HOW DOES THIS ARGUMENT HELP MAKE THE CASE FOR INVESTMENT?

When deciding whether to provide public resources, it is important for the providers to know that those resources will be used well and will ultimately contribute to societal wellbeing and fiscal sustainability. This argument can be used through either a positive or a negative lens. Health stakeholders may demonstrate that a certain aspect of the health system is already operating efficiently, thus showing that it is a good steward of its resources and will use additional funding well. Alternatively, stakeholders may demonstrate that the system is underperforming, and that the only way for them to improve their efficiency levels is through receiving additional funding. As detailed in Box 4, efficiency is an area of key policy concern, so this can be an important argument to harness when making the case for public investment in health; however, efficiency arguments should be framed cautiously to fit the specific needs and contexts of a situation, and to avoid unintentionally providing a potentially specious rationale for less funding for health.

SELECTED EXAMPLES OF TOOLS, DATA AND INDICATORS TO SUPPORT THE ARGUMENT

- Allocative efficiency analyses
- Auditing tools
- Expenditure reviews
- Health System Performance Assessment (HSPA) Framework
- Price comparisons
- Technical efficiency analyses
- Tracer conditions

ARGUMENT 5: THE PUBLIC (PARTICULARLY VOTERS), NON-GOVERNMENTAL ORGANIZATIONS AND CIVIL SOCIETY GROUPS CARE ABOUT ISSUES RELATED TO HEALTH AND THE HEALTH SYSTEM AND THINK MORE FUNDING IS WARRANTED

OBJECTIVES

This argument can be used to show that by investing in health, policy makers are acting in a way that meets the needs, demands and/or preferences of their constituents. Thus it can demonstrate that additional funds for health are not only a good decision for health, economic and social outcomes, but also for political ones.

FINANCE POLICY GOAL(S) IT CONSIDERS:

- Demonstrating good stewardship of public resources
- Supporting societal wellbeing

ADDRESSES COMMON CONCERNS AROUND INVESTING PUBLIC FUNDS IN HEALTH BY:

- Demonstrating that health systems make major contribution to health improvements, and thus the public depends on and cares deeply about them

OVERVIEW

In a well-functioning and cohesive society, policy makers' public spending decisions should be influenced (at least in part) by the needs, demands and opinions of the populations which they serve. By making this argument and harnessing the engagement of the public, civil society organizations and non-governmental bodies, health financing advocates can show that funding for health is a worthwhile investment that society – and in particular voters – care deeply about.

HOW DOES THIS ARGUMENT HELP MAKE THE CASE FOR INVESTMENT?

Elected officials – those who have the ultimate power over and final say on public financing decisions – ultimately serve the public. By the nature of their roles, they care about and are influenced by their constituents, including individuals, civil society organizations, non-governmental bodies, etc. A strong argument for increased public funding for health can be made by demonstrating that it is what the people – and particularly voters – want. If those making the case can show budget holders that the public depends on and cares deeply about a well-functioning health care system, this can serve as a good push to put health higher on the budget priority list. Engaging with and harnessing the powerful voices of civil society groups, NGOs and affected individuals can be a strong resource in negotiating for additional funding for health. After all, many budget decisions are influenced by politics. Thus budget cases can demonstrate that funding for health is a worthwhile investment for not only health and societal wellbeing, but also for political outcomes.

SELECTED EXAMPLES OF TOOLS, DATA AND INDICATORS TO SUPPORT THE ARGUMENT

- Leveraging the voice of civil society
- Social preferences data
- Patient satisfaction data

5. Mapping the tools, data and indicators that can support arguments for public investments in health

5.1 Argument 1: Health system investments address health needs and improve health, and without adequate funding, there will be adverse consequences

5.1.1 Overview

The main objective of a health system is to address health needs and improve population health. Health systems must also be responsive to expectations and demand, and serve populations equitably so as not to cause financial hardship for users of health services (Murray & Frenk, 2000). As a result, one of the main and possibly most frequently made arguments for additional investments in health is simply that health systems need more resources to maintain and improve population health outcomes. This is especially salient as demographics shift and as prices for health services rise due to inflationary pressures and expensive innovations and medicines being released onto the market. While this line of argument can be used with a more positive lens that highlights the health needs that can be met and improvements that can be made with additional funding, it can also be used to demonstrate the consequences of inadequate funding or a do-nothing scenario. In other words, strong budget cases which use Argument 1 may describe the projected losses and harms to population health and health systems if the requested funding is not supplied.

While improved health outcomes are not the primary objectives of finance policy makers, it is important for them to see that public finances are contributing to a good standard of living overall, and that resources are being used well. It is beneficial to demonstrate that spending on health will result in its intended objectives and contribute to population health (or alternatively, that inadequate spending on health will result in adverse consequences to population health and shortfalls in meeting health system objectives).

Before describing specific examples of tools, data and indicators that can be used to prove that health systems address health needs and improve health, it is worthwhile to note that while health systems are typically best placed to improve health outcomes, there are some improvements in health which come from policies, programmes and interventions beyond the health sector. This is described further in Box 3. Highlighting the beneficial impacts that other sectors have on health may be an important way to demonstrate the intersectoral and interdisciplinary nature of health; however it may not always be an effective way to advocate for greater investment in health, as it is a one-way relationship

5.1.2 Tools, data and indicators to support the argument

Argument 1 is commonly used when making the case for additional health funding. Many health systems in the EU have a variety of fairly easily accessible tools, data and indicators to demonstrate how investment in health systems can lead to improved health (or how underinvestment will lead to adverse consequences for health). For example, the connections between health expenditure and improved health can be shown through decreases in amenable mortality and child mortality (Martin, Rice & Smith, 2008; Çevik & Taşar, 2013; Gallet & Doucouliagos, 2017; Mackenbach et al., 2017; Gabani, Mazumdar & Suhrcke, 2022).

Amenable mortality data identify deaths from a collection of conditions that are potentially avoidable given effective and timely health care (Mackenbach et al., 2017; Kruk et al., 2018). Eurostat provides yearly estimates of preventable and treatable mortality in EU countries (Eurostat, 2023). The OECD also provides yearly estimates of avoidable mortality, defined as deaths before the age of 75 from preventable conditions (OECD, no date: a). Several studies have compared amenable mortality between EU countries (Jarčuška et al., 2017; Mackenbach et al., 2017; Costa & Santana, 2021). Mackenbach et al. (2017) found that higher levels of health care spending were associated with greater health equity and lower mortality from amenable causes

Box 3 **While the health system is typically best placed to improve health outcomes, not all improvements in health come from the health system**

A **health in all policies** approach aims to capture health-related outcomes from policies outside the health sector. This is a prominent approach used in high-income countries to connect health with other sectors. It is commonly seen in transportation, housing, food and climate policies. The potential effect of these policies is typically measured using **health impact assessments** (HIAs) (Collins & Koplan, 2009). While this approach is important and useful to highlight the intersectoral and interdisciplinary nature of health, *it may not always be an effective way to advocate for greater investment in health, as it describes a one-way relationship.*

A common example of the health in all policies approach is lobbying for cycling-friendly infrastructure, which may help increase physical activity and reduce chronic disease. When deciding whether to use this approach, advocates for increased public funding for health must be careful not to accidentally provide a rationale for disinvestment in health by implying that investments elsewhere will lead to better health on their own.

An alternative is the **health for all policies** approach. Briefly, this says that improvements in health status enable greater economic, education and societal participation and productivity, thus contributing directly to policy goals in other sectors. (This is discussed in more detail in section 5.2.) The two approaches – health *in* all policies and health *for* all policies – differ in terms of their direction, so the health for all policies approach may be simpler to use when making the case for investment in health. As Greer et al. note, a health for all policies approach can demonstrate how improved health can benefit other sectors (e.g. education, workforce, etc.) rather than the other way around (Greer et al., 2022).

in seven EU countries. Countries with high amenable (or preventable, treatable or avoidable) mortality and low spending levels may be able to make a case that by spending more, deaths due to these causes are likely to decline, particularly over time. Countries with lower levels of amenable (or preventable, treatable or avoidable) mortality and higher spending levels may still be able to use this line of argument by demonstrating that they need additional funds to maintain these good population health outcomes and that there will be adverse consequences if health budgets do not rise with increasing pressures on the health system.

Argument 1 can be used to make the case for investments in particular health areas as well. For example, **5-year survival rates for cancers** may help convince budget holders to spend additional funds on specific cancer treatments or care programmes. **Childhood obesity rates** can be used and framed to make the case for increased investment, including: (1) funding for prevention and nutrition programmes so that the prevalence decreases over time, and (2) increased spending in chronic disease management areas, as these children are at risk of staying obese into adulthood and their chances of developing diabetes, cardiovascular diseases, etc. will increase. (UK Cabinet Office et al., 2017).

Infant and child mortality data may highlight the need for investments in certain areas of maternal or paediatric care. A global analysis identified a significant relationship between increased health expenditure and reductions in infant and child mortality, while a second study noted greater effects in high-income countries (Bloom & Canning, 2003; Currie, 2006). **Health care mortality data** may help identify specific facilities or surgery areas which could benefit most from increased funding (linked closely with Argument 4 around efficiency). Alternatively, these data may serve as a strong example of the consequences of inadequate funding. For example, a study examining the association between public spending on health care and **maternal mortality** in the EU over a thirty year period found that a 1% decrease in government health care spending was associated with a 10.6% annual increase in maternal mortality (Maruthappu et al., 2015).

Other consequences of insufficient funding for health care include access issues and inequities. Data and indicators which can be used to demonstrate the level of health care access in a country include **levels of unmet health care needs** and **waiting times for health care procedures**. High levels of unmet needs for health care are typically attributed to financial challenges, geographic barriers or long waiting times. Therefore this measure is highly sensitive to health care expenditure. For example, higher out-of-pocket payments and lower total public expenditure on health care are associated with higher levels of unmet health care needs in Europe (Milner et al., 2021). Longer waiting times are typically the result of health care demand outweighing the supply of health services, so they are also highly subject to levels of expenditure. In an analysis of OECD countries, growth in health care expenditure was linked to reductions in waiting times (Haines, 2017). Waiting times are a particularly salient political issue in many countries and efforts to reduce waiting times are likely to be politically popular (this has strong links/overlaps with Argument 5). Using these indicators in budget cases for health can help demonstrate the key areas where funding is needed and is likely to have a large impact.

Many of these data and indicators are made publicly available through government sources or data platforms hosted by international organizations such as the World Bank, WHO or OECD. Some are also highlighted in user-friendly reports which provide a narrative around them. For example, the European Observatory and the OECD, in cooperation with the European Commission, release *State of Health in the EU – Country Health Profiles* biennially (European Observatory on Health Systems and Policies & OECD, 2021, 2023). These reports provide concise and policy-relevant overviews of each EU country's state of health and health system. They highlight key challenges for health in each country, and also describe recent policy initiatives that have been linked to policy improvements. Information on the state of health at the country-level and key opportunities for health systems improvements can also be found in the WHO's European Health Information Gateway (WHO Regional Office for Europe, no date), the Commonwealth Fund's *International Health Care System Profiles* (Commonwealth Fund, 2023), the European Observatory's *Health Systems in Transition series* (HiTs) (European Observatory on Health Systems and Policies, 2021b), etc.

Table 1 outlines examples of tools and indicators covered in this section.

Table 1 Selected examples of tools and indicators used to support Argument 1

Tool/indicator	Description of application of tool/indicator to make the case for investments in health
5-year survival data for cancers, etc.	The 5-year survival rate for cancer measures the percentage of patients with cancer who are alive 5 years after their initial diagnosis. This measure is often used to track the effectiveness of cancer treatments and to compare survival rates between different types of cancers and at different stages. This figure can be combined with cost-related data to compare the effectiveness of treatment at different stages, helping to identify potential benefits of investing in prevention and treatment.
Amenable mortality data	Amenable mortality refers to deaths from a collection of conditions that are potentially avoidable given effective and timely health care. Identifying specific causes of death that are amenable to health care interventions can help point to areas where increased investment in health care services could have the greatest impact.
Avoidable admissions to hospital (e.g. to advocate for primary care)	Avoidable admissions are hospitalizations that could have been prevented or managed through appropriate and timely primary/community care. Identifying specific interventions and conditions that are driving avoidable admissions can show where additional financial resources are most needed and will have the most impact. For example, avoidable admissions may be the result of inadequate access to primary care, poor quality of care or a lack of coordination between health care providers.
Data platforms and publicly available country reports with health system indicators	Many of the data and indicators mentioned in this section are made available publicly through government sources or data platforms hosted by international organizations. There are also regular country-level reports which provide a narrative around these figures. Examples include the State of Health in the EU – Country Health Profiles (European Observatory on Health Systems and Policies & OECD, 2021), the European Health Information Gateway (WHO Regional Office for Europe, no date), the International Health Care System Profiles (Commonwealth Fund, 2023), the Health Systems in Transition series (HiTs) (European Observatory on Health Systems and Policies, 2021b), etc. These can serve as a useful source of data and provide insights into the types of narrative that these indicators can support.
Health impact assessments	Health impact assessments (HIA) are used to identify the potential health impacts of policies, programmes and projects in non-health sectors such as transportation, housing or energy. To perform a HIA, researchers conduct a comprehensive assessment of the potential health impacts of the policy, programme or project in question. This includes considering both direct and indirect health impacts, as well as impacts on health determinants such as housing, education and employment. As discussed in Box 3, this can provide important and useful information to highlight the intersectoral and interdisciplinary nature of health. However, it describes a one-way relationship and may not always provide useful support for a narrative around why more should be invested in health.
Unmet need	Measures of unmet need for health care spending can be used to make the case for greater overall health spending and more funding for specific areas within health. Comparing measures of health care outcomes with health expenditure, affordability and accessibility measures helps to determine if additional funding for health is required to meet population health needs. In Europe unmet need is typically measured using household surveys. Examples of such surveys include: a) the EU statistics on income and living conditions (SILC); b) the European health interview survey, and c) the Commonwealth Fund's International Health Policy Survey. In these surveys, respondents are asked about the coverage of health services and goods, and the reasons for unmet needs (e.g. waiting times, distance to health care facilities and costs associated with health care).
Waiting times	Waiting times for health services can be a useful measure to support budget cases for greater investment in health expenditure. In many EU countries, reductions in waiting times can be linked to increased total health expenditure. Longer waiting times mean that demand outpaces supply and more health care appointments and services are needed than the health system can provide. The OECD and others have shown that longer waiting times may result in greater levels of unmet need and worse health inequalities and health outcomes. Using waiting time metrics can be an important way to demonstrate the impacts of insufficient health expenditure or a lack of funding for a specific area within the health sector.

5.2 Argument 2: Health system investments further societal goals and have co-benefits beyond the health sector, including increased financial protection

5.2.1 Overview

Not only do well-functioning and well-funded health systems produce good health outcomes, but they also play a crucial role in financial protection for individuals and in growth opportunities for the broader economy and other sectors – both directly and indirectly. The line of argument that an investment in health is also an investment in the economy, in education and in the social sector more broadly aligns with several public finance objectives and may be a valuable framing option in negotiations between health and finance stakeholders. As first highlighted in section 2 above, health systems directly and indirectly contribute to societal wellbeing. They improve population health outcomes which in turn can lead to higher levels of financial protection, labour force participation, educational attainment, gender equity, etc. These can have a positive impact on the economy by increasing participation, productivity, inclusivity and equality in the workforce.

5.2.2 Tools, data and indicators to support the argument

Healthier people are more likely to engage with school, work and society more often and over a longer period of their life course than those who are burdened by illness and disease. For example, there are strong links between obesity and smoking with unemployment, lower wages and/or poorer productivity levels (OECD, 2015). Populations with chronic disease and/or in ill health consistently have higher levels of **absenteeism** and **presenteeism** compared to healthier populations (Jans et al., 2007; Vuong, Wei & Beverly, 2015; Fitzgerald et al., 2016; Skagen & Collins, 2016; Fouad et al., 2017; Destri et al., 2022; OECD, 2015). By making investments that maintain and improve people's health over their lifetimes, policy makers can ensure greater workforce participation and productivity, leading to better economic outcomes overall.

This is especially salient as demographics are shifting and many populations in Europe are ageing. While an increase in the older population as a share of a total population may reduce real per capita GDP growth, evidence suggests that this decline will be moderated if the older population is in good health (Cylus & Al Tayara, 2021). Demonstrating that economic slowdowns due to ageing may be avoided through increased funding to support healthy and active ageing (with data and evidence to support this) may be a successful way to convince finance stakeholders that investment in health is worthwhile.

Ill health of individuals affects their human capital development at all stages of life. For example, children in poor health are less likely to attend school on a regular basis, hindering their future development and lowering their chances of economic success. Ill health may also reduce an individual's ability to invest in further education and training (Bloom & Canning, 2003; Currie, 2006).

Investments in health also have direct and indirect impacts beyond the economy. For example, poor menstrual health and hygiene (MHH) can lead to girls missing classes or even dropping out of school altogether (World Bank, 2022). Poor access to safe and affordable sanitary materials to manage menstruation can pose risks of infection which can have cascading effects on sexual and reproductive health (World Bank, 2022). The impacts of poor MHH on education enrolment and attendance and sexual and reproductive health can have long-term consequences on female contributions to the overall economy, and gender equality more broadly (World Bank, 2022). In efforts to make progress in this area and in recognition of the co-benefits it can lead to, several countries including the UK, Kenya, Australia and Germany have reduced or removed taxes on MHH products, and many schools, colleges and organizations around the world provide free menstrual hygiene products in women's and/or gender neutral toilets.

There is also substantial evidence demonstrating that increased health expenditure can promote equity and improve financial protection (Cylus, Thomson & Evetovits, 2018). For example, people on lower incomes on average spend a larger share of their earnings on health in those EU countries with higher out-of-pocket expenditure levels (OECD, 2019a). Ensuring that health systems do not rely disproportionately on households to pay for their health care can be a strong argument for additional funding, particularly given that access to health care without financial hardship is a cornerstone of the UHC agenda. There are many ways to measure the risk of financial hardship due to out-of-pocket payments. Cylus, Thomson and Evetovits examined various methods for calculating **catastrophic health spending** in Europe, finding that the normative spending on food, housing and utilities method developed by the WHO Barcelona Office for Health Systems Financing was most relevant for policy purposes (Cylus, Thomson & Evetovits, 2018). This type of analysis has been used to develop a series of country reports (*Can people afford to pay for health care?*) which take an in depth look at financial protection in the WHO European Region and the drivers of financial

hardship due to out-of-pocket payments (WHO Regional Office for Europe, 2023). Country reports such as these can serve as key resources for policy makers in making arguments for more funding and identifying specific areas for further investment.

The health system itself is also an important and innovative industry that is a major source of stable employment in many economies. The health sector not only encompasses health care workers and administration, but also research and development, medical technology, pharmaceuticals and digital health. The European Observatory has produced a series of country snapshots on the contributions of countries' health sectors to their economies (European Observatory on Health Systems and Policies, 2021a). The economic snapshots demonstrate that the health sector is a significant source of employment, making up more than 7% of total employment in the countries studied to date. Further, the snapshots show that the health sector has been a stable source of employment over the past two decades. This provides evidence for the budget case narrative that an investment in the health system and its infrastructure, as an industry, is a key way to maintain financial stability. These types of short analyses can be useful to draw attention to the economic potential of the health system.

The above discussion refers to what has been termed a **health for all policies** approach (see Fig. 3) (Greer et al., 2022). This describes how improvements in health status enable greater economic, education and societal participation and productivity, thus contributing directly to policy goals in other sectors. It also demonstrates how investments in health policies also indirectly benefit other policy objectives beyond health. It serves as a way to conceptualize the relationship between health and other sectors, and enables the health sector to promote and push for health on the policy agenda because of the co-benefits it has beyond health (Greer et al., 2022). **Co-benefits** refer to the achievement of several interests and/or objectives resulting from a single political intervention, where the benefits of one policy contribute to one or more others, including beyond that sector. A health for all policies approach moves away from a one-sided concept of the relationship in which the health sector only benefits from other sectors (often referred to as a health in all policies approach as described in Box 3), to a multidirectional relationship where other sectors benefit from improvements in health and vice versa (Greer et al., 2022).

Figure 3 **Greer et al.'s causal pathways in health for all policies**

Source: Reproduced from Greer et al., 2022.

While they have potential to be a strong argument to build the case for increased health investments, co-benefits from health systems are often difficult to measure accurately due to methodological challenges driven by their interdisciplinary nature. As Greer et al. explain, "[**measuring co-benefits**] is more dependent on sector-specific knowledge of causal mechanisms as well as contextual factors such as budgeting procedures, urban design, or labour law" (Greer et al., 2023). Nevertheless, Greer et al. (2023) outline how to measure co-benefits in three steps. The first is to identify and understand the relationship between the health care system, related policies and the issue in question. This step could include the development of a logic model that outlines important and relevant mechanisms. The second step is to develop a logic model of how the policies influence the relationship identified in the first step. The final step is to identify policies or actions with significant potential co-benefits and the most realistic chances of success and implementation. This requires developing quantitative estimates (using tools described in Table 2) to assess the benefits of a given policy. It also requires further analysis of the organizational, regulatory and structural barriers to implementation. It is important to reiterate that reliably estimating the co-benefits of health policies is difficult because health intersects with many external factors. Quantifying co-benefits is therefore most effective at the micro level, with clear, logical pathways identified between health policies and outcomes.

Several types of analyses can be used to quantify the causal link between health programmes and policies and other societal goals, using **experimental designs** and **quasi-experimental designs** and quantitative methods like **regression analysis**. Two common quantitative techniques include **difference-in-difference** (where some groups are exposed to a policy, but others are not) and **regression discontinuity** (where individuals below a threshold are compared with those just above a cut off point). Both experimental and quasi experimental designs can be used to determine the extent to which health programmes and policies are causally linked to other societal goals such as reducing poverty or improving educational outcomes.

For example, a Danish study demonstrated that experiencing a heart attack or stroke reduced earnings by 18% and overall household income by 3.4% (Fadlon & Nielsen, 2021). A **cost-benefit analysis** (CBA) can be particularly useful for measuring co-benefits if designed in a way to include costs and effects beyond the health domain. While CBA is commonly used to measure the benefits of new technologies and assess whether they should be included in health benefits packages, it is possible to use CBA in areas beyond health technology assessment. For example, the OECD recently applied CBA methods to assess the intersection of environmental and health policies (OECD, 2018). As discussed in section 6, the ability to use these methods to demonstrate the effects of the health sector on non-health-related outcomes is very much dependent on the design of the policies themselves and the capacities (time, resources, etc.) of those undertaking the analyses. If done well, however, this causal link between health and other sectors can provide strong evidence to incorporate into a narrative around why more (and/or better) public spending on health is needed.

Table 2 outlines examples of tools and indicators covered in this section.

Table 2 Selected examples of tools and indicators used to support Argument 2

Tool/indicator	Description of application of tool/indicator to make the case for investments in health
Catastrophic health expenditure data and/or financial protection reports	Catastrophic health expenditure refers to health spending that exceeds a certain threshold of income, or expenditure that can lead to financial hardship or impoverishment. High levels of impoverishing or catastrophic health expenditure occur when households have inadequate financial protection mechanisms. Catastrophic health expenditure data can be used to help make the case for increased investment in health by demonstrating the impacts of health/ill health on poverty, household savings and economic growth. These data demonstrate the health co-benefits of establishing or strengthening financial protection. A 2023 report entitled *Can people afford to pay for health care* "summarizes the findings of a new study of financial protection in 40 countries in Europe, including the whole of the European Union (EU), in 2019 or the latest available year before the coronavirus disease pandemic" (WHO Regional Office for Europe, 2023).
Cost-benefit analysis	As implied by its name, CBA identifies all the direct and indirect costs and benefits associated with a given intervention, project, programme or policy. It is used to evaluate the economic efficiency/value of the intervention, project, programme or policy in question. Cost-benefit analysis measures outcomes in monetary terms and enables the inclusion of costs and benefits beyond the domain of health. Thus CBA can be a useful tool to support the case for greater funding for health by quantifying the potential benefits and co-benefits that these investments would have on health, the economy and beyond. Quantifying co-benefits is often easiest/most effective when done on the micro level, with clear, logical pathways identified between health policies and outcomes.
Data on absenteeism	Absenteeism refers to the frequent or prolonged absence of employees from work, and it can have significant impacts on labour market productivity. Linking measures of absenteeism with health determinants and disease rates can be used to support the investment case for health. For example, linking labour market absenteeism with chronic disease risk factors and/or disease prevalence can establish the association between health and workforce participation, and help make the case that health has macroeconomic co-benefits (or that ill health has macroeconomic consequences).
Data on presenteeism	Presenteeism refers to employees being physically present at work but not being fully engaged or productive due to physical or mental health challenges. Similar to absenteeism, measures of presenteeism can be linked with health determinants and disease rates to support the investment case for health. For example, linking presenteeism with self-reported mental health scores can demonstrate how increasing access to public mental health support through increased funding would be beneficial to workforce productivity.
Experimental designs	Experimental designs involve randomly assigning individuals or groups to different interventions or treatments to determine their effect on an outcome of interest. In the context of health systems, experimental designs can be used to determine the effect of a specific health intervention on both health outcomes and societal level outcomes, such as employment, income, etc. This evidence can then be used to demonstrate to budget holders what potential impacts on wellbeing can be achieved by increased investment in health.
Quasi-experimental designs	Quasi-experimental design research methods are similar to experimental designs but do not involve random assignment of participants to different groups. In the context of health systems, quasi-experimental designs can be used to examine the impact of health interventions or policies on broader societal level outcomes beyond health. This evidence can then be used to demonstrate to budget holders what potential impacts on wellbeing can be achieved by increased investment in health.
Health and the economy snapshots	The European Observatory has produced a series of Health and the Economy snapshots on the contributions of countries' health sectors to their economies (European Observatory on Health Systems and Policies, 2021a). These show that the health sector has been a stable source of employment over the past two decades. Evidence from these snapshots may support the case that an investment in the health system and its infrastructure, as an industry, is a key way to maintain financial stability in a country. These types of short analyses can be useful to draw attention to the economic potential of the health system when making the case for investments in health.
Regression analysis	Regression analysis examines the relationship between two or more variables. In the context of health systems, external policy goals and co-benefits, regression analysis can be used to better understand the relationship between system inputs and outputs, and other societal level outcomes beyond health which are conditional on a set of other factors. When designed and implemented appropriately, regression analyses can help demonstrate and quantify the wider co-benefits of health system investments.

5.3 Argument 3: Health system financing can (or will) be sustainable following additional investments

5.3.1 Overview

In some cases, there may be opportunities for health stakeholders to demonstrate that additional spending is likely to lead to greater financial sustainability. Particularly in health systems that are systematically underfunded, investing more in the health sector presents the opportunity to adopt more efficient processes (linked to Argument 4), and therefore produce greater returns on investment than an underfunded system (linked to Arguments 1 and 2). This can help appease a common concern among those making public financing decisions that spending always begets more spending. If greater spending is seen as an investment in improving the functioning of the health system rather than being a cost with limited additional gain, it may be easier to convince budget holders to provide additional funds. However, given the political nature of public expenditure where elected governments often prioritize short term wins over medium to long-term improvements, this can be challenging if the improvements are likely to accrue over many years.

Sustainability in the health financing system refers to the capacity to generate sufficient revenues to continue financing the health system inputs. Ensuring that health systems receive sufficient financing is particularly important as health expenditure increases relative to GDP growth. Sufficient and sustainable financing is also critical when considering the changes to future demand due to impacts of the COVID-19 pandemic, continued population ageing, the rising burden of chronic disease, and concerns around the supply of health care workers. Each of these issues raises the importance of sustainability, especially as a large proportion of funding for health is derived from public sources. These factors will continue to result in increased demand for health services; therefore, additional investment is required to ensure that health systems are able to maintain and possibly enhance their capacity to deliver effective services that meet the needs of the populations they serve.

As with Argument 1, it is possible to frame Argument 3 in a more positive way, focusing on how additional investment leads to sustainability, or to use it to highlight that without increased funding, the health system will be unsustainable. It is also important to mention here that sustainability of health investments not only hinges on *more* spending, but also on *better* spending (WHO Council on the Economics of Health for All, 2021; Forman, Permanand & Cylus, 2024). Thus this argument can be used to advocate for greater health spending, and it can also be used in negotiations to decide how to best allocate existing health budgets.

5.3.2 Tools, data and indicators to support the argument

There are currently **forecasting models** and **projection tools** that can be used to consider the sustainability of health systems (or highlight their unsustainability without changes to public spending). These models and projections can help shed light on the factors that drive growth and how new investments will influence these. They can provide evidence to support arguments for additional and better investment into specific areas which will contribute most to health system sustainability over the medium to long term. The national health expenditures and insurance enrolment model of the Centers for Medicare & Medicaid (CMS) in the United States projects time series data across all of the major spending categories in the American national health expenditure accounts (Poisal et al., 2022). For example, it predicts annual public funding, private and out-of-pocket funding across the three largest goods and service categories (hospitals, physicians and clinical services, and retail prescription drugs). The OECD produces health spending projections up to 2030. The estimates are produced across a range of policy situations, including a base scenario (no policy changes) and several other alternative scenarios, such as improvement to productivity or lifestyle improvements (Lorenzoni et al., 2019). These regression-based models require long time series to be useful, which may not be available in all countries. In addition, the European Observatory developed the Population Ageing financial Sustainability gap for Health systems (PASH) Simulator to forecast how population ageing will affect health financing (European Observatory on Health Systems and Policies, no date). The PASH tool goes beyond the standard approach for assessing health financing sustainability by examining how both health expenditure and revenues are affected by changes to population age distributions (Cylus et al., 2022; European Observatory on Health Systems and Policies, no date). The tool is simple but can be easily adapted to individual country health financing contexts. As policy makers and influencers consider funding options, these projections and models are a useful way to explore policy options and the impact that different scenarios are likely to have on health and financing outcomes.

It is important to consider the usefulness and limitations of forecasting methods when using them to advocate for more and better financing for health. Forecasting involves predicting future events or trends based on available data and assumptions about how these data will evolve over time. The quality of forecasting therefore depends on the accuracy of the data and

assumptions used. All forecasting models involve uncertainty, and it is critical that these uncertainties are discussed when communicating findings. It is also important to communicate the range of potential outcomes and their associated probabilities so that policy makers have a clear understanding of the degree of uncertainty in the forecast. Thus projections should be accompanied by **sensitivity analyses**, as these test the impact of different assumptions on the forecasted outcomes.

Several costing exercises and economic evaluation tools (e.g. **cost effectiveness analysis, cost minimization analysis, cost utility, cost benefit analysis**) can be used to identify specific health areas with high potential for growth (in quality, efficiency, etc.) if they received additional investment. Findings from these exercises can help explain why and how additional and better spending in certain health areas will contribute towards health system sustainability (Shiell et al., 2002).

After health care demands were forecasted, the Romanian government increased the 2017 budget for health by 23.6% compared to 2016, recognizing that the current level of health spending was insufficient to meet the needs of the population in both the short and long term (Gabriela Scîntee, Vlădescu & Hernández-Quevedo, 2017). The budget increases were dedicated to specific sectors in the health system that were highlighted as key potential impact areas in the forecast models, including improving access to medicines, building initiatives relating to three regional hospitals, producing medical technology for hospitals, and vaccines. This increased funding was intended to ensure that the health system in Romania had a sufficient level of resources to continue producing its desired outcomes and outputs in the future.

Table 3 outlines examples of tools and indicators covered in this section.

Table 3 **Selected examples of tools and indicators used to support Argument 3**

Tool/indicator	Description of application of tool/indicator to make the case for investments in health
Cost-benefit analysis	Cost-benefit analysis is used to assess the costs and benefits of a project, policy, programme, etc. in monetary terms. It is a technique employed in economics to evaluate the efficiency of different options and determine whether the benefits outweigh the costs. Cost-benefit analysis can be used in making the case for public investment in health by highlighting areas where funding will contribute to the most gains/growth.
Cost-effectiveness analysis	Cost-effectiveness analysis can be used to demonstrate the sustainability of health financing by comparing the costs and benefits of different health interventions or programmes. By assessing the cost per unit of health outcome achieved, cost-effectiveness analysis can help health systems identify the most effective use of resources.
Cost-minimization analysis	Cost-minimization analysis can be used to demonstrate the sustainability of health financing by comparing the costs of alternative interventions or programmes that have equivalent health outcomes. By identifying the least expensive alternative, cost-minimization analysis can help health systems optimize their use of resources and ensure that they are directed towards programmes and services that deliver the same health benefits at the lowest possible cost.
Cost-utility analysis	Cost-utility analysis is another type of economic evaluation that extends the principles of cost-benefit analysis to incorporate other measures of health outcomes and quality of life. It evaluates the costs of a project, policy or programme and its impact on health-related quality of life. It can be used in making the budget case for health by highlighting areas where funding will have the greatest impact.
Economic evaluation	Economic evaluations (including cost-benefit analyses, cost-effectiveness analyses, cost-minimization analyses, cost-utility analyses, etc.) can be used to demonstrate the sustainability of health financing by assessing the costs and benefits of health interventions and programmes. By comparing the costs and benefits of different interventions or programmes, economic evaluations can help health systems identify the most effective and efficient use of resources. This can then be used to support greater investment into those specific health areas which will have the most impact.
Projections and forecasting	Projections and forecasting methods can be used to demonstrate the sustainability of health financing by providing estimates of future health expenditure and revenues, and comparing them to the expected growth of the economy and other factors that affect health spending. They are important tools to help understand and explain the factors that drive growth and how new and/or better investments in health will influence these. Projection and forecasting methods commonly analyse how factors such as demographic changes will influence health service demands and access. Projecting and forecasting methods can also be used to estimate the impacts of future expenditure as a result of policy or financing changes.

5.4 Argument 4: The health system has the capacity to effectively and efficiently use additional resources

5.4.1 Overview

When making the case for increased resources, it is important to demonstrate that the health system is already a good steward of its existing resources. This suggests that the system is likely to be able to absorb new public monies efficiently without waste. Conversely, in some settings it may be more appropriate to show that more public funding is needed in order to achieve greater efficiency and absorptive capacity in the health system. Before using efficiency arguments to negotiate for additional funds, it is important to carefully consider what the best framing is, given the specific context and stakeholders involved (see Box 4).

Inefficiencies create several problems for health systems and have drawbacks that extend beyond the health sector. An inefficient use of resources in the health system may deny patients potential health gains when they receive care (Cylus, Papanicolas & Smith, 2017). Furthermore, inefficiencies consume excess resources which could have been better used elsewhere (either within or outside of the health sector). They also may undermine a society's willingness to contribute additional funds to health services. Thus the argument for investments which will improve efficiencies can prove compelling to public budget holders.

5.4.2 Tools, data and indicators to support the argument

Efficiency analyses can demonstrate that investments in heath will produce better health and generate value for money. There are two common concepts of efficiency in health care: allocative efficiency and technical efficiency (Cylus, Papanicolas & Smith, 2016). **Allocative efficiency** refers to the allocation of resources to achieve the outcomes at the least cost. Examples of tools to measure allocative efficiency include **health technology assessments** (HTAs), which commonly use **cost per quality-adjusted life years** (QALYs) to determine whether adopting a new treatment or technology is worthwhile given its cost (Cylus, Papanicolas & Smith, 2016). Other measures of allocative efficiency examine the potential benefits and/or improvements of re-allocating resources or services within the health sector, such as avoidable hospital admissions, antibiotic prescribing and excessive referrals to hospital specialists. In principle, improvements in allocative efficiency can be achieved without additional spending, although in practice spending better may still require spending more.

Technical efficiency is defined as producing the greatest outputs or outcomes for a given level of inputs, or producing the same outputs at a lower cost (Cylus, Papanicolas & Smith, 2016). Basic indicators of technical efficiency include the number of consultations per doctor in a specified time frame, the number of operations per surgeon, the price per input, the length of stay for a condition, or care duplication. One method of determining technical efficiency uses **diagnosis-related groups** (DRGs), which cluster patients into a

Box 4 **Considerations when using efficiency and inefficiency arguments to advocate for more health funding**

While efficiency is a key policy concern, health stakeholders should be cautious in the way they frame efficiency arguments so that they best fit their specific needs and contexts.

Demonstrating that a health system already achieves good outcomes given its level of resources can make a strong case for further investment. However, it may be difficult to show convincingly that there will be constant (or increasing) returns for additional spending.

Instead, efficiency analyses may reveal some degree of waste in a system. A common reason for inefficiencies is that there are insufficient resources. Demonstrating inefficiencies due to a lack of resources may be a strong argument for increased investment in health in certain contexts; however, in others it may further the narrative that health systems misallocate their resources or are wasteful, and make it difficult to argue in favour of investment.

Importantly, research suggests that when health systems do manage to demonstrate that they achieved efficiency savings, these often do not translate into more resources for health in the long term as those savings are returned to the overall public sector budget (Barroy et al., 2021). So there is a risk that in seeking to improve efficiency, ultimately budgets will be cut over time. Caution should be used when devising narratives around efficiency gains to avoid unintended consequences.

Efficiency analyses should be presented in a way that stimulates discussion around why inefficiencies or waste may be occurring. For example, stakeholders could highlight how insufficient inputs such as health care workers, medicines and equipment are causing inefficiencies. When using efficiency indicators, it is important to contextualize and present the results with complimentary analyses that place the findings in the broader context of the health system and show the full picture, rather than as a standalone analysis.

manageable number of groups that are homogeneous with respect to medical condition or expected costs. Actual DRG costs at a hospital can then be compared to a national reference cost, providing useful information on the technical efficiency of a specific health care organization by comparing patients with similar characteristics and needs. Another important measure of technical efficiency could be **price comparisons**, as paying excessive prices for the same goods or services is a common source of inefficiency. Ideally, price indexes should be calculated to reflect the actual basket of services provided; more generic price indexes, such as consumer price indexes, are not likely to adequately reflect health system prices (Lorenzoni & Koechlin, 2017).

In addition to economic tools to demonstrate efficiency, public expenditure reviews, health expenditure reviews and audits can also be used to identify areas where resources for health are generated and spent efficiently (as well as sustainably, as per Argument 3 above), and areas where there is room for improvement. **Public expenditure reviews** consider the whole macroeconomic context and demonstrate how health expenditure compares to other sectors. **Health expenditure reviews** consider revenue sources and costs. For example, the European Observatory has produced such a review for Slovenia (*Slovenia: health system review*) (Albreht et al., 2021). The review identified high susceptibility to labour market fluctuations and high reliance on complementary health insurance to ensure financial protection in Slovenia, leaving a number of budget items either underfunded or not funded. Such a review can be used to direct resources towards areas which will attain the greatest efficiency gains. **Auditing** is similar to public expenditure reviews. However, audits use the sub-sector level to systematically evaluate care and identify areas for improvements (Hut-Mossel et al., 2021). Audits can compare health facilities' compliance with external criteria, such as adherence to policy guidelines and clinical protocols. In the context of advocating for more public funding for health, audits can be used to demonstrate that actors within the health system are making good use of the resources they currently receive and are worthy of more investment.

Performance indicators can also help demonstrate where health systems are operating efficiently and where they could do better. This information can be used either to make the case that the health system already has the capacity to use its resources well and so additional funding will be used effectively and efficiently, or to show that the health system needs more funding to rectify inefficiencies that are driven by insufficient resources. **Health system performance assessment** (HSPA) frameworks can provide useful snapshots of how well a health system is performing against its objectives (Papanicolas et al., 2022; Rajan et al., 2024; WHO Regional Office for Europe, 2024). These frameworks typically consider the functions and sub-functions of a health system and link them to key assessment areas, making them useful tools to explore connections throughout the health system as well as identify the performance of specific health system components. They also consider how inputs to the health system generate key outputs and outcomes such as health improvements, financial protection, efficiency and equity (Papanicolas et al., 2022). While performance indicators alone can be oversimplistic and easily gamed, the benefit of an HSPA framework is that it is comprehensive enough to monitor different facets of health and their complex relationship to one another. This can be used to identify priority areas requiring additional investment. The **tracer condition** approach is a method which is used to evaluate the performance and quality of the health care system and its services. The method carefully follows and examines aspects of the health care system related to a specific health issue (tracer condition). It can be used to identify gaps in care delivery, assess the effectiveness of health care interventions, monitor progress towards specific health goals, and guide policy decisions to enhance the overall quality, performance and efficiency of the health care system. For example, when using diabetes as a tracer condition, the mortality-to-incidence ratio can indicate where potential quality issues lie (Nolte, Wait & McKee, 2006). Linking closely to and overlapping with Argument 1 around health gains, the tracer condition approach can be used to support Argument 4 by highlighting particular areas where additional (or better targeted) funding will be most impactful in addressing health needs, strengthening health system practices and efficiencies, and thereby improving health system performance and sustainability (linked to Argument 3).

As described in Box 4, the promise of efficiency gains is often used to negotiate for additional funding for health. A framework developed by Barroy et al. (2021) aims to ensure that efficiency gains actually translate to greater budgets in practice. The framework identifies three enabling conditions: (1) choosing a well-defined intervention that targets health system inputs and is implemented over a medium-term time frame, (2) choosing an intervention which generates measurable financial gains that can be quantified before or after implementation, and (3) having a public financial management system which allows finance gains achieved through greater efficiency to be kept within the health sector or re-allocated towards specific health needs (Barroy et al., 2021). When countries and/or health systems do not meet these three conditions, it is unlikely that the deceleration of health expenditure growth from efficiency improvements will be translated into increased budgets over time. Instead, this may unintentionally demonstrate that the health sector is

able to do more with less resource and thus result in budget cuts. Therefore, paradoxically, in certain contexts there may be disincentives to making arguments around efficiency in the sector.

Table 4 outlines examples of tools and indicators covered in this section.

Table 4 Selected examples of tools and indicators used to support Argument 4

Tool/indicator	Description of application of tool/indicator to make the case for investments in health
Allocative efficiency analysis	Allocative efficiency analyses such as HTA, or indicators such as avoidable hospital admissions, antibiotic prescribing and excessive referrals to hospital specialists, can demonstrate that health systems are effectively (or not) distributing resources within the health system. In the context of using them to advocate for more public funding, these indicators and tools are best used when demonstrating that the health system will make good use of new resources. While these can be a useful tool, it is important to exercise caution when using efficiency analyses to make the case for more funding, as they have the potential to create misapprehensions that the health system is either a) using its resources efficiently and does not need more funding, or b) using its resources inefficiently and therefore should not be given additional resources (see Box 4).
Auditing tools	Audits are useful for demonstrating if specific organizations, institutions, facilities and providers are optimizing their current resources. Examples of audits can be presented to finance decision makers to demonstrate how actors within the health system are using resources at present, and make the case that increasing funding would promote further improvements within the health system.
Expenditure reviews	Expenditure reviews can be used to demonstrate the sustainability of health financing by providing a comprehensive analysis of the efficiency and effectiveness of health spending. By identifying areas of waste or inefficiency, expenditure reviews can help health systems optimize their use of resources and ensure these are directed towards programmes and services that deliver the greatest health benefits.
Health system performance assessment framework	The health system performance assessment framework allows policy makers to assess performance. It provides a description of the four health system functions – governance, resource generation, financing and service delivery. The framework allows users to identify sources of underperformance in the health system functions and sub-functions through the indicators in the assessment areas. The framework can also be used from right to left to examine variability in the health system goals or intermediate outcomes relative to other countries or a set of benchmarks, to trace back sources of variations in the functions or sub-functions. Overall, it is a useful tool to understand how the health system works and how functions and sub-functions are linked to the assessment areas that explain performance, and also identify health system bottlenecks that contribute to challenges.
Price comparisons	Price comparison allows countries or health system payers to compare differences in the prices of goods and services. For example, comparing the costs of a basket of services or drugs between two different insurers can be used to identify if a health system is paying excessive prices for those services or drugs.
Technical efficiency analysis	Technical efficiency analyses, such as assessments of the number of consultations per doctor in a specified time frame, the number of operations per surgeon, the price per input, the length of stay for a condition, care duplication or DRGs, are especially useful for demonstrating that the health system is performing at a high level and achieving its objectives, and therefore can use more funding to successfully produce desired outcomes (or conversely, that it is underperforming and needs more funding to improve).
Tracer conditions	The tracer condition approach uses carefully selected indicators for several health problems to profile the strengths and weaknesses of service delivery within a health system (also linked to Argument 1). For example, one study identified a series of tracer conditions which could be used to shed light on primary health care performance in the WHO European Region and identify policy priority areas (Barbazza et al., 2019). The selected tracer conditions and services included postnatal care, influenza, tuberculosis, hypertension, heart disease, diabetes type II, chronic obstructive pulmonary disease, asthma, breast cancer, cervical cancer, colorectal cancer and depression. The tracer condition approach can generate evidence to support the case for public investment in health by identifying inefficiencies in service delivery (where more funds could be directed for improvements) or efficiencies (where more funds could be directed since they are already good value investments).

5.5 Argument 5: The public (particularly voters), non-governmental organizations and civil society groups care about issues related to health and the health system and think more funding is warranted

5.5.1 Overview

Policy makers can be influenced by: public and civil society needs, opinions and demands; voter preferences; political lobby movements; etc. Ultimately, their job security and electability hinges on this. When a society demands improvements in health and health care systems, action and investment often follow. This was evident during the COVID-19 pandemic, when governments responded by immediately supporting health and health care systems. For example, many high-income countries increased health spending to support their health system's response to the pandemic and to develop and purchase vaccines (Forman, Permanand & Cylus, 2024). A key approach when making the case for public investment in health is to demonstrate that societies, and particularly voters, NGOs and civil society organizations, place a high value on adequately funded health and health care systems.

5.5.2 Tools, data and indicators to support the argument

Across Europe and other high-income countries, voters have demonstrated that they value strong health care systems. There are several tools for generating information about public priorities and preferences. This includes **public opinion polls**, which can be used to produce information on voters' overall priorities and preferences for how public funds should be spent. For example, 69% of respondents in a 2019 poll said that health care costs should be top priority for the United States government and Congress. (Pew Research Center, 2019). Similarly, a Eurobarometer survey in autumn 2021 found that 42% of Europeans ranked public health as the highest among all policy issues (European Union, 2022). Public opinion polls are also useful to identify priorities *within* the health system. For example, a poll was carried out in the United Kingdom in 2022 to identify the top public priorities for the National Health Service (NHS). Respondents named addressing staff workloads (37%), increasing health care workforce numbers (36%) and improving waiting times (35%) as their top priorities, while minimizing the health system's impact on the environment (>1%), improving the standard of care at hospitals (10%) and expanding services aimed at ill health (11%) were the lowest priorities (Buzelli, Cameron & Gardner, 2022). Arguments for increased investment in health can be backed by these data and evidence which show that more funding is necessary to meet the needs and demands of the public.

Patient satisfaction is another important indicator of the value that the public places on health. When the public is satisfied with the services they receive, they may be more likely to advocate for increased investment in health to maintain this level of care. Areas of dissatisfaction (e.g. long waiting times as discussed in Argument 1) may also drive the public to demand health system improvements and thereby advocate for increased spending to enable this. Patient satisfaction can be measured through surveys and analysing patient feedback. Examples include patient-reported experience measures (PREMs) to assess patient-reported experiences of receiving care (Kingsley & Patel, 2017). An example of PREMs is the OECD's Patient-Reported Indicator Surveys (PaRIS) initiative, which works to standardize indicators of patient outcomes and experiences across countries (OECD, no date: b). The PaRIS initiative has developed two surveys, one on chronic conditions and the other on hip replacements. The PaRIS survey and other PREMs aim to assess whether health systems are truly delivering what patients value. Other survey vehicles which have indicators that could be leveraged include the European health interview survey (EHIS) and the EU statistics on income and living conditions (SILC).

As well as using the indicators above, **social participation** – engaging with people, communities and civil society – can help identify key reasons for and drivers of good or poor performance within the health system (e.g. barriers to access). This in turn can help make the case through identifying top priority areas for investment, either because they are already achieving good population health outputs, or because improvements are needed. Additionally, social participation can help make the case for increased investment in health as it improves the chances of greater efficiency and responsiveness (linked to Argument 4): if people are involved in decisions around their health and health care systems, they will be more likely to actually take up the services which public monies have been invested in (WHO, 2023).

Civil society organizations and/or patient groups can also be effective in supporting the case and lobbying for increased investment in health. Civil society organizations play a key advocacy role and can often lobby for change (and increased funding) through direct disease awareness or public health campaigns. Similarly, patient and clinical groups may try to drive change or increased investment in specific areas through media campaigns or industrial action or protests. Because of

the political nature of these actions, they may convince policy makers to act. Additionally, many of these groups collect data and information that can be useful in supporting Arguments 1 to 4 above. When making the case for additional funding for health, it is important to engage with these groups and with the public more broadly to get their support and buy-in.

Table 5 outlines examples of tools and indicators covered in this section.

Table 5 **Selected examples of tools and indicators used to support Argument 5**

Tool/indicator	Description of application of tool/indicator to make the case for investments in health
Social participation and leveraging the voices of civil society	While not technically a tool or an indicator, people, communities, civil society and patient/clinical stakeholder groups can play an essential role in making the case for public investment in health. Lobbies and campaigns by these groups can provide political fuel to drive action and real change. Institutionally anchoring social participation can help ensure that the health areas promoted for public investment are ones that align with public preferences. When making the case for additional funding for health, it is important to engage with these groups and with the public more broadly to get their support (including access to data and evidence) and buy-in.
Patient satisfaction data	Patient satisfaction data, such as PREMs, are important for demonstrating that the public values their health and health system, and therefore further investment is a good political idea. Patient satisfaction data can also be useful when the public is dissatisfied with a specific area within the health system, especially when health is of high societal value, as increasing investment may be a top priority among the public.
Social preferences data	Social preferences data, such as public opinion polls, are important tools for demonstrating that voters want policy makers to invest in health systems. Given that health is a priority among the population, these public opinion polls can be extremely valuable in reminding financial decision makers that investing in health aligns with the preferences of voters and the public consensus.

6. How is evidence used in practice, and where are the opportunities for improvements in negotiations between health and financing?

The five arguments and the associated tools, data and indicators revealed through the literature review serve as an important starting point for understanding how to better engage and make the case for investing in health. However, there is a lack of empirical evidence of how and whether countries adopt these approaches and tools in practice, and if they result in increased investment or better use of resources in health. We supplemented the findings from the literature review with interviews with health and finance stakeholders in several European countries to better understand if and how these approaches and tools were used in practice. Through the interviews, we also identified potential opportunities and challenges in supporting health stakeholders and advocates to make stronger investment cases for health.

Several factors emerged during the interviews as key enablers of success in building convincing cases for additional investments in health. The main ones were:

- robust data and the capacity to analyse it
- clear health priorities
- effective communication which aligns with policy goals and priorities and builds trust
- building institutional arrangements for stakeholder engagement
- advocacy and engagement with the public, civil society and other non-government stakeholders
- identifiable economic and social benefits
- regional and international comparisons
- evaluation and learning.

In this section, we describe each of these factors and draw on real world examples of best practice and related challenges.

6.1 Robust data and the capacity to analyse it

Robust data and the capacity to analyse it are fundamental elements in building a compelling case for increased funding for health. To advocate for additional resources, it is essential to provide solid evidence that demonstrates the impacts of underfunding, and the gains that can be made with adequate financing for population health, health care outcomes and overall system effectiveness (see Box 5). Generating this strong evidence base does not just hinge on data availability and access, but also relies on having the capacity to conduct technical analyses.

6.1.1 A lack of data availability can pose challenges

Certain data may be hard or impossible to generate and get access to, thus preventing analyses that could be useful in making a case. Stakeholders in Austria noted that since there is no price transparency on drugs used in inpatient settings in their country, it is impossible to perform certain economic evaluations which could provide evidential support for some sustainability and efficiency arguments in those settings. Many interviewees also explained that while health co-benefits to the economy and the labour sector might be of great interest to finance decision makers and, in theory, could be used to support a strong budget narrative, these are very difficult to measure and quantify in practice. The knock-on effects of health are difficult to track and also are likely to be influenced by confounding or intermediary factors. One expert suggested that it may be most useful to start with very small and specific measures when assessing co-benefits to better track the influence of funding. Financial stakeholders also agreed that generating specific information on co-benefits and efficiency of health systems would be useful to promote accountability

Box 5 **Selected examples of using data to advocate for increased funding for health**

During the interviews, an expert described a case for investment in breast and colorectal cancer screening in Spain. Historically, screening for these cancers was covered for those with a family history, but under the proposal this would be expanded to all those 50 years of age and older. Arguments for this were largely based on epidemiological evidence on the added value that expanding the screening programme would have to health outcomes and costs over time. This highlights how having appropriate data and models – even relatively simple ones – can play a crucial role in successfully making the case for investment in health.

An interviewee from Estonia also highlighted the role of data in making the case for increased public investment in health. In 2018, Estonia successfully began to secure a broader revenue base for its health system and introduced a reform that fixed the co-payment fees for medicines, lowered the threshold for additional benefits on high-cost prescriptions, and automated calculations for reimbursement of additional benefits at the point of purchase. In the years before this reform was implemented, health stakeholders had been demonstrating to finance and other relevant decision makers through data and long-term forecasting that with population ageing and other pressures, the health system would not be sustainable based on revenues from payroll taxes alone. Projections demonstrated that the do-nothing scenario would result in broad health consequences. When a political party which had aligning priorities came into power, there was a window of opportunity to push this case forward, and the case for investment in health was ultimately successful.

within the health sector and potentially support its investment case over the medium and long term.

6.1.2 Both data and analysis capacity are important to successfully make the case for increased public investment in health

While some interviewees noted data gaps and inaccessibility, others stressed that even when data are available, the capacity and resources to adequately analyse and communicate them are often lacking. A Belgian stakeholder pointed out that, while there are data and evidence on health outcomes, determinants of health, social inequities and structural inequalities which can be used to support certain arguments for funding for health, little work is being done on programme evaluation. While the data measures mentioned are useful for forecasting future need, these projections may not provide a holistic picture of the total value of the health system. Thus in countries where the ministry of health or other relevant bodies may not have the time, the finances or other resources available to conduct more intricate data analyses, the case for investments in health may need to rely more heavily on arguments around health needs (Argument 1), which are simpler to assess and demonstrate.

Therefore, as health stakeholders and policy makers work to improve budget cases for health, they may in fact want to dedicate more of their own resources to data and evidence generation and access, and to data analysis capacity-building efforts. However, it is important to note that training in highly complex technical analyses may be unnecessary. Simpler analyses, including techniques involving regression analysis (e.g. difference-in-difference), are often more applicable to a wide range of investment cases and easier to communicate and build a clear and understandable narrative around (as discussed further in section 6.3) than more complex mathematical models such as system dynamic modelling.

6.1.3 Negotiation settings may be highly political, leaving less space for data and evidence

Interviewees highlighted that even when both data and analysis capacity are available, there may still be limited use of these in budget negotiations. As one interviewee from an evidence-generation background noted, there is "never a very clear linear relationship between our scientific insights and … actual decisions and discussions". This alludes to the often-political nature of negotiations for health financing.

In summary, data, evidence and the capacity to analyse them can help decision makers to understand the costs associated with suboptimal health outcomes, increased health care system utilization and productivity losses, and to comprehend the potential benefits and gains that could be achieved with increased investment. Several tools, data and indicators – many of which are highlighted in the sections above – can be useful in supporting the investment case for health. However, data are only one piece of the health financing negotiation puzzle. Other factors influence whether the data are used effectively to make the case for health. Afterall, as one interviewee noted, "data is [just] data" – data are not enough on their own.

6.2 Clear health priorities

As public resources are limited, ideally any additional resources should be directed towards the areas that require the most urgent attention and investment. Identifying clear priorities – especially ones which provide the most value for money (Forman, Permanand & Cylus, 2024) – can help provide a more focused

and compelling narrative for health investments when entering into negotiations (discussed further in section 6.3 below). Further, it can help those building the case for increased investment strategies: both in terms of what arguments will be most likely to convince policy makers to direct extra resources to health, and in identifying exactly how the funds will eventually be used to have the most impact.

6.2.1 Clear priorities can help provide a focused and compelling budget case for health but challenges remain

It is important to note that clear health priorities may not always link easily or neatly to the priorities of those holding the public purse strings. For example, stakeholders from several countries described difficulties with negotiating for increased funding for primary health care and prevention areas, despite them being priority health areas. As mentioned above, even though it makes intuitive sense that prevention and primary care will contribute to better population health outcomes, which in turn can lead to better educational, economic, equity, etc. outcomes, it can be difficult to accurately model and quantify the full effects of this – especially at the population level. Decision makers may be hesitant to commit funding when there is uncertainty about what the potential impacts would be. Further, those who have the final say in where public monies are directed may place the most priority on areas which have the largest potential short-term gains. After all, the political cycle is relatively short, so if they want to maintain good public opinion and/or improve the chances of re-election, policy makers frequently need to demonstrate how their decisions have created positive impacts. As interviewees highlighted, if the benefits of investment in a health area such as primary care or prevention may not be realized for another ten years, these may be less attractive for budget decision makers who are unlikely to stay in the same position over that period. One interviewee from France explained, "spending is in the year to come, but the results will be later", and stressed that it was often difficult for policy makers to take a multi-year vision in decision making. In many countries, financial decision makers may be keener to invest in areas (e.g. certain novel health technologies) which can generate quick excitement and buzz, even when they are not high health priorities with demonstrated value for money.

6.2.2 Awareness of how health priorities align with finance stakeholder objectives can help in recognizing and capitalizing on windows of opportunities

Early awareness of how health priorities align (or do not) with finance stakeholders' priorities can prove crucial to a successful budget case. This allows those making the case to invest more effort and care into crafting arguments for clear health priorities through framing which is most likely to resonate with financial decision makers. Additionally, and importantly, it also allows advocates to capitalize on political windows of opportunity when they arise. For example, one interviewee noted certain areas, including cancer and women's health, had been underfunded for many years, but recently, these had become political priority areas and were now financed quite well in her country. Windows of opportunity are discussed in further detail in section 7.

As with evidence, clear priorities provide the foundation for building a strong case for increased funding and ensuring that resources are directed towards the areas that will have the most substantial impact on population health and wellbeing; however, on their own they are not often sufficient for successful negotiations. These clear health priorities will often need to be combined with good evidence, effective communication, cooperative engagement, trust, transparency, etc.

6.3 Effective communication which aligns with policy goals and priorities and builds trust

Not only is there often a mismatch between health and financial priorities, but health and finance stakeholders also often lack common language, systems and incentives (Kanthor & Erickson, 2013). As Geert van Maanen, former Secretary General of the Ministry of Health (2007-2013) and former Secretary General of the Ministry of Finance (1999-2003) in the Netherlands, explains in a video, finance stakeholders may often feel that the health sector is constantly asking for more money even when their public budgets are already growing much faster than others in the public sector (WHO Regional Office for Europe, 2018). Meanwhile, health stakeholders may often feel like their systems are providing immense value for society by saving lives and keeping people living longer, healthier and more productive lives, but that this goes unnoticed and unrewarded by finance policy makers who regularly say no to budget increases (WHO Regional Office for Europe, 2018). As one health expert interviewed imagined, "[in an ideal world, finance stakeholders would see] that the gains that they are going to get out of an investment are much larger than the investment

itself". When making the case for additional funding for health, it is vital that health stakeholders consider the perspectives and objectives of finance stakeholders, and communicate in ways that clearly and simply demonstrate that health budgets are well spent and give value for money. In essence, successfully making the case is not just about having the data that demonstrates that this financing is needed and/or valuable, but it often hinges on how well these data are communicated and framed to meet the policy goals and priorities of those holding the purse strings.

6.3.1 Successful budget cases for health do not just hinge on evidence, but also on the ability to create convincing and understandable narratives to frame that evidence in a way that meets public finance language and objectives

During the interviews several stakeholders noted the importance of communicating and framing arguments for health in ways that aligned with public finance language and objectives. One stakeholder explained that it would be ideal if health representatives in her district were able to go to representatives from other sectors (including finance) and have them understand the total value that health systems provide (including to sectors beyond health). However, she noted that health does not currently speak the right language for this message to resonate widely. Finance stakeholders often highlighted that in order to consider increases to financing for health, they would need more specific information on how the health system uses its funds currently, and evidence that the health system had control over waste. A health stakeholder from Ireland discussed an example of when additional funding for health was successfully secured, and stated, "It's sometimes how you sell things. … [In this case] the language, the words and the arguments we made to our friends in the Department of Finance rang true with them".

6.3.2 Communication between policy makers (and with other stakeholders) facilitates transparency and trust, creating a more hospitable environment for negotiation

Effective communication is also key to building transparency and ultimately trust. As McKee et al. (in press) highlight, policy makers' trust in the health system is crucial "for adequate resource allocation and transformation". Trust requires: fostering collaboration, communication and communication across sectors; encouraging co-production; recognizing the value of lived experience; and including stakeholders, civil society, the media and the public in decision making (McKee et al., in press).

Effective communication which aligns with policy goals and priorities is naturally linked to other enablers highlighted in this report. It requires that stakeholders understand one another's priorities (as discussed above in section 6.2) and have ways to engage with each other (discussed below in section 6.4). Further, it can be used to quickly capitalize on windows of opportunity when they arise (discussed in section 7).

6.4 Building institutional arrangements for stakeholder engagement

Stakeholder engagement and regular communication pathways between decision makers in health and finance can help build successful cases for public investment in health by bringing diverse perspectives together, building consensus, enhancing relevance, and improving accountability and trust. While health stakeholders tend to focus on the health benefits, finance stakeholders may be more interested in efficiency, accountability and absorptive capacity of the health system, as well as broader potential economic gains or co-benefits of additional health funding.

6.4.1 Building in regular channels for stakeholder engagement can help policy makers move towards the development of a common language, understand constraints and recognize windows of opportunity

Regular engagement can help trigger and facilitate some of the other enablers discussed in this section. For example, if stakeholders meet with each other, they will have a better sense of how to communicate with one another and use a common language. Regular engagement also facilitates an understanding of stakeholders' priorities and objectives, the contexts in which they are operating and the constraints they face. This raises opportunities for aligning priorities and building trust and consensus. This is particularly useful in navigating the balancing act between financing decisions which satisfy the short-term political agendas and needs of policy makers and achieving longer-term improvements in health outcomes as discussed in 6.2. Further, regular stakeholder engagement can allow those who are making the case for public investment in health to more quickly and easily identify windows of opportunity when they arise (discussed in section 7).

6.4.2 There is also a role for reputable non-governmental organizations and representatives to play in moving the budget case for health forward through evidence generation and negotiation processes

Across several of the interviews in this exercise, a light was shone on the benefits that regular stakeholder engagement can create, and the challenges that a lack of it can pose. One interviewee noted difficulties in finding a common understanding between health and finance stakeholders in her country and explained that there was no direct engagement between the ministry of finance and the national health insurance fund. Another stakeholder discussed a recent policy dialogue on population ageing and the role of demand and supply side mechanisms in improving home care in her country. The stakeholder stressed the importance of having key players in the same room to develop understanding and consensus. She also highlighted the role that reputable international or national non-governmental organizations can play in these discussions and in evidence generation (as discussed in section 7). Box 6 highlights an example from Estonia of the type of governance arrangements that can enable regular communication and consensus building between health and finance.

6.5 Advocacy and engagement with the public, civil society and other non-government stakeholders

Alignment of the case for additional investments in health with the objectives and values of influential individuals, civil society organizations and other non-governmental actors can help build leverage in negotiations. Linked strongly with Argument 5 in the framework, third-party engagement can help facilitate public support for the health system, which in turn can convince policy makers that increased funding for health is needed (or at the very least, that health funding should not be cut).

6.5.1 The public, communities, civil society organizations and other non-governmental stakeholders can play an important role in advocating for budgetary changes

There are many examples of civil society groups playing an influential role in driving change for health financing. For example, recent demonstrations and walk-outs of health workers in countries around the world have placed health worker remuneration and working conditions as key issues on the political agenda

Box 6 **Governance arrangements in Estonia to facilitate regular communication and alignment between health, finance and other sectors**

The Health Insurance Fund in Estonia is managed by a management board, which reports to a supervisory board. The management board is responsible for management functions as outlined by law and by the decisions of the supervisory board. The management board also is responsible for preparing development plans and budgets to be submitted to the supervisory board for approval. The management board consists of three to seven members, including one chairperson. This chairperson is designated by the supervisory board.

The supervisory board is currently made up of just six members, though previously it has consisted of more. Importantly, the Minister of Health and the Minister of Finance are automatic members of the board, ensuring the active engagement and buy-in of high-level policymakers. Parliament designates one Member of Parliament as a member of the supervisory board following the proposal of the Social Affairs Committee. The board also includes representatives of the insured and of employers.

At the time of writing, the supervisory board consisted of:

- Minister of Health (Rina Sikkut)
- Minister of Finance (Mart Võrklaev)
- Chairperson of the Estonian Chamber of Disabled People (Ulvi Tammer-Jäätes)
- Member of the Estonian Trade Union Confederation (Elle Pütsepp)
- Chairperson of the Estonian Employer's Union (Arto Aas).
- Member of Estonian Employer's Union (Andi Kasak)

Management and decision-making processes – particularly around budgets – are designed to directly involve high-level actors from the ministry of health, the ministry of finance and elsewhere. This provides regular opportunities for these stakeholders to engage in dialogue. Not only can this facilitate understanding around health and finance needs and objectives, but it can also enable connections, shared language and trust to be built, thus providing a middle-ground between health and finance which can potentially result in more aligned budgets.

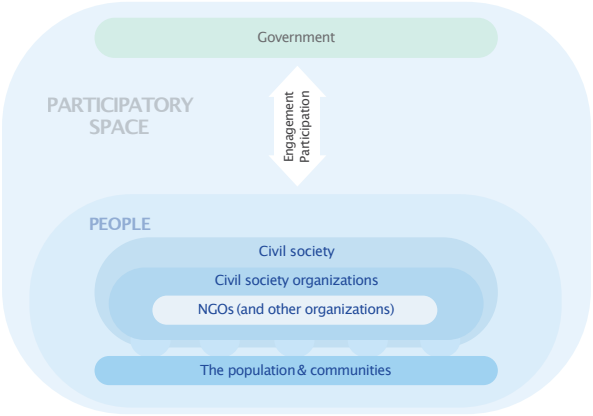
Source: Tervisekassa (no date)

(AP NEWS, 2023; Brophy & Sriram, 2023; Mihai, 2023; Rodriguez & Gore, 2023). These sorts of efforts can be traced back several decades: for example, the AIDS Coalition to Unleash Power (ACT UP) was one of "the most influential patient advocacy groups in history … and they ultimately forced the [US] government and the scientific community to fundamentally change the way medical research is conducted" and funded (Aizenman, 2019).

In recent years, there has been increased acknowledgement of and attention to the important role social participation can play in the push towards UHC by "ensuring that health policies are responsive, equitable and effective" (WHO, 2023). Establishing and facilitating participatory spaces can ensure that there is an institutionally anchored place for people to engage and participate in the decision-making process (see Fig. 4) (Rajan, Koch & Rohrer-Herold, 2021). These may include: in-person, open-for-all forums; invitation-only consultative methods (e.g. policy dialogues, focus groups); deliberative engagement methods (e.g. citizen panels, citizen juries); or legal frameworks which fix seats for populations, communities and/or civil society in decision-making processes (e.g. health councils, health committees, representation on steering groups) (Rajan, Koch & Rohrer-Herold, 2021).

Even if these groups and stakeholders are not actually in the room when budget negotiations take place, their political support and advocacy can be harnessed so that the priorities of finance stakeholders begin to shift and align closer with health ones. However it is important to note that because patient or medical professional groups by their nature are often limited to a specific disease area, their priorities will not always align with each other's and/or with health finance priorities, and may even conflict. To give a hypothetical example, a children's cancer patient group may lobby heavily for coverage of a highly expensive treatment with lifesaving potential, but which will only affect a very small number of people, and has limited evidence on its cost effectiveness or value. Meanwhile, another patient group might advocate for coverage of a less expensive drug with good evidence of its value and effectiveness and which will impact a large proportion of cardiovascular disease patients. At the same time, health policy stakeholders may have access to evidence which suggests that additional funds for health could achieve the most return on investment if they were directed to capacity-building programmes and increased remuneration for nursing staff. These competing priorities can be difficult to navigate, but it is essential to do so. Engagement with these groups and individuals can help those advocating for increased funding for health to understand various priorities, build consensus, and develop a budget case for mutually agreed priorities.

Figure 4 **Ensuring budget decisions reflect people's needs, preferences and contexts: building and institutionally anchoring participatory spaces**



Source: Reprinted from Rajan, Koch & Rohrer-Herold (2021).

One interviewee discussed the important influence that civil society groups have in France. The interviewee explained that even though they are not directly present in financing negotiations, patient or clinical professional associations can put pressure on the government through the media, political lobbying, etc. to invest more in health. The interviewee also highlighted that civil society groups are not necessarily united, and sometimes successful lobbying by one group may lead to increased funding for that disease area, but can result in funding cuts for another disease area.

Interviewees also pointed out that when making the case for additional funding for health, having support and evidence-based backing from internationally and/or nationally reputable organizations outside of the government can be very helpful. This involvement from an unbiased third party can help build trust between health and finance stakeholders. An interviewee from Ireland explained how having a reputable organization participate in a recent policy dialogue and present evidence they had generated was important for convincing decision makers that selecting mechanisms to improve home care was important and should be done carefully. It garnered trust by showing finance stakeholders that third-party evidence was in line with the arguments that the health sector was making, and thus that the case for investment was reliable.

6.6 Identifiable economic and social benefits

Linked strongly to 6.1 and 6.3 above, it is easier to make a good case for increased investment for health when the potential economic and social benefits are

clear and simple to communicate. However, as noted several times above, it often can be difficult to measure the population-level medium to long-term direct and indirect economic and social benefits of investments in health.

6.6.1 The quantification of budget impacts is often easier to carry out on smaller-scale studies or pilot interventions

It may be more feasible to quantify the impacts of pilot interventions and programmes than at a broader system level. Successful pilot cases that measure impacts on a smaller scale can still provide useful evidence to support arguments that health benefits, health co-benefits, efficiency gains and sustainability improvements can be achieved with increased investment in health.

Interviewees noted examples of how pilot studies which demonstrated economic and social benefits of health interventions, programmes and policies catalysed additional funding for health. For example, one interviewee from Ireland discussed how focusing on narrower areas of health or specific interventions or programmes where public monies had been directed were often easier to trace and to show their impacts. This type of evidence can be particularly useful in demonstrating efficiencies in the health care system, and that the health system can and will use additional funding it receives well (Argument 4).

An interviewee from France highlighted efforts that had been made in recent years to move towards evidence-based funding decisions. Now an annual report is released which covers analyses of the evolution of expenditure and practices in health, and based on these proposes avenues to improve quality, efficiency of care and optimization of health spending in the subsequent year (Assurance Maladie, 2022). For example, the latest report included evidence on the effects of programmes which had provided general practitioners (GPs) with additional remuneration for providing certain quality or prevention services that aligned with national health targets, as well as evidence on the impacts of the national *100% Santé* scheme which provides full coverage to a certain basket of auditory, optical and dental equipment and services (Assurance Maladie, 2022).

6.6.2 Identifiable economic and social benefits of health can help make arguments for health funding stronger, but they are rarely sufficient on their own

While clear evidence of the economic and social benefits of additional investment in health is often insufficient on its own to make the case for health, it certainly makes arguments for health funding stronger. It can help enable those advocating for additional finance to discuss return on investment and efficiency gains and thus make it easier to speak a common language with public finance stakeholders (as in 6.4 above).

6.7 Regional and international comparisons

International trends and comparisons can play an important role in achieving successful budget negotiations for additional funding for health.

6.7.1 Policy maker priorities in one place may be influenced by what is happening nearby and how it compares

Political priorities are often influenced by what is happening in neighbouring regions, countries, districts, etc. Financial policy makers may pay closer attention to cases for investments in particular health areas for which their country, region, district, etc. seems to be falling behind others with similar economic, political and social contexts. Similarly, policy makers may be keen to invest in trending areas of health if they see that many of their counterparts from other regions, countries, districts, etc. are doing so. An interviewee from Spain highlighted an example where a regional health authority introduced gender-affirming care into its health benefits package about a decade ago, and then other regions in the country followed suit. While coverage for this service is still not available nationally, discussions around this are ongoing, and progress has been made in pushing gender-affirmative health care forward (Council of Ministers, 2022). An interviewee from Ireland said that country comparisons and case studies may lead to growing interest from financial decision makers in particular health areas. For example, if decision makers in an EU country sees that many other Member States are investing in cancer or other non-communicable diseases, they may be more likely to follow suit. Thus it is important for those making the case for increased investment in health to be aware of what is happening in other countries (or regions, districts, etc. depending on the level of negotiation), and to harness and frame this knowledge in a way that creates a convincing argument for funding.

6.7.1 Comparisons can also help to pinpoint what does and does not work in the budget negotiation process between health and finance stakeholders

Country comparisons can serve other purposes. As a stakeholder from Belgium noted in an interview, country comparisons and best practice case studies are also useful in identifying what works and what does not work when it comes to the actual negotiations. Linked to 6.5 above, comparative data and benchmarking can also help promote accountability between governments and the public, and in some cases can help health stakeholders garner the support of civil society groups and non-governmental organizations. Comparing health expenditure indicators between similar countries, such as the proportion of GDP allocated to health or per capita health expenditure, can help to understand a government's overall commitment to health. More specific indicators, such as the proportion of health expenditure allocated to primary health care, can provide insight into a government's health priorities. Comparisons can serve as a starting point to enable energy and resources for a specific health area to grow by generating interest and attention, by demonstrating that a country or region is falling behind its neighbours in terms of health or wellbeing outcomes, or by simply showing what has worked for others during their own negotiations.

6.8 Evaluation and learning

While it was not often a large focus in the interview discussions, it is important to highlight the role that evaluation and learning can play in enabling trust and how they may eventually lead to successful negotiations for health financing. Linked closely with 6.1, 6.6 and with efficiency arguments when making the case (Argument 4), strong monitoring and evaluation in health is key to demonstrating accountability and that extra resources will be used effectively. As described in 6.6, evaluations are being used to inform financial decision making in France. Publishing and/or sharing evaluations with relevant stakeholders can help garner transparency and ultimately trust between decision makers. Thus evaluation and learning, and the accountability, transparency and trust that they generate, can help build momentum for further investment in health over time.

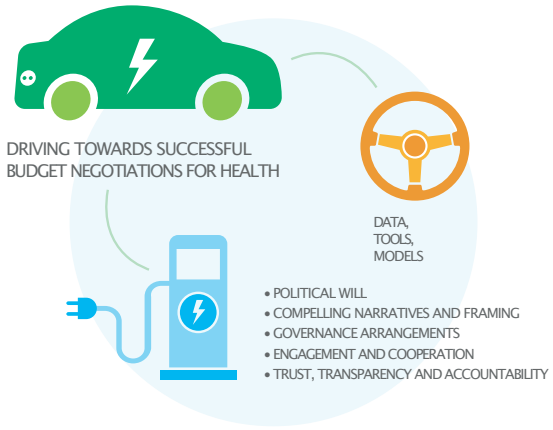
6.8.1 Evaluating what has and has not worked helps promote learning for improvement

Evaluating what works and does not work in negotiation processes, and building institutional knowledge based on this experience, could also be an important practice to improve the negotiation capacity of health stakeholders. While this practice may already be used in some places, none of the stakeholders interviewed identified any types of institutional arrangements for this in their countries. As such, there may be opportunity for ministries of health, national insurance funds and other bodies which engage in budget negotiations to record successes and challenges in their experiences with investment cases over time. These can then be analysed and strategies changed based on what the evidence suggests works and does not work in these processes.

7. The role of evidence and negotiation in obtaining funding for health

Our literature review and interviews highlighted that while there is an important role for data, tools and models in making the case for public investment in health and in setting the policy agenda, they are insufficient on their own. These sources of information can help steer decision makers to make good choices (or at least to avoid making bad ones), but – continuing with the driving metaphor – the fuel to push the budget case forward successfully consists of: political will; compelling narratives and framing; governance arrangements; engagement and cooperation; and trust, transparency and accountability (see Fig. 5).

Figure 5 **The steering role of evidence in driving successful negotiations for health**



7.1 A large share of spending on health is determined by existing algorithms

When thinking about and developing cases for increased investment in health, it is important to consider the practical realities of how health budgets are determined, and acknowledge that the room for negotiation may be constrained. In many countries, a large share of the spending for health is based on existing algorithms (see Box 7). When we discuss negotiating for additional funding for health, we are usually referring to negotiations for additional budget or benefits packages at the margins of the overall budget.

7.1.1 There is still room for negotiation, but it is important to build in protections and ways of guaranteeing reliable funding levels

This is not to diminish the important role that evidence can play in helping to successfully get more money for health, and ultimately to improve health outcomes and societal wellbeing. Instead, this just reiterates that there is no silver bullet when it comes to obtaining additional finance for health, and no tool that can be universally applied to tell policy makers exactly what they will get if they increase their GDP spend on health by a certain percentage. While it is important to build capacity for negotiating for additional finance, it is also essential to build in protections and ways of guaranteeing a reliable level of funding into the system that are not dependent on negotiations.

Box 7 **A large share of health budgets are determined by formulas: the case of Belgium**

A large share of the Belgian budget for health is fixed for recurring costs, as determined by previous expenditure. However a small proportion of funding, called the annual growth norm, is flexible. The annual growth norm is intended to adjust for growth and inflation in the health budget. The growth norm was set at 2.5% for 2023 but has ranged from 1% to 4% in previous years. The growth norm is typically decided through a combination of projected expenditure based on the previous year and political priorities; the latter can be influenced through data but the process of doing so is often political and opaque.

7.2 Capitalizing on windows of opportunity is key when it comes to negotiations between health and finance

While many national health budgets are mostly determined by formulas, there is still some scope for negotiation for additional investment in health, and one important way of doing this is to recognize and capitalize on windows of opportunity when they arise.

7.2.1 Good timing and quickly recognizing and acting on opening windows of opportunity is often a feature of successful negotiation

Multiple interviewees noted how essential timing was to successful negotiations for increased funding for health. For example, an Estonian interviewee stated, "a lot of it [successful negotiation] depends on the timing as well", while an Irish interviewee stated that negotiation success often hinges on "using opportunities and just fortunate timing". While the arguments, tools, data and indicators highlighted in this report can provide compelling reasons why health funding is needed, without windows of opportunity where political will for change is strong, the budget case for health investment is less likely to be successful.

7.2.2 Certain institutional arrangements can help with recognizing and capitalizing on windows of opportunity

As discussed above in section 6.4, certain arrangements and features can enable those making the case for additional public investments in health to recognize and capitalize on windows of opportunity when they arise. Regular engagement with stakeholders in and outside of the government can garner a good understanding of the political environment and the political interest in health. Regular engagement may also enable health stakeholders to quickly recognize when external influences or events or changes in leadership occur that present windows of opportunity where finance stakeholders may be more receptive to arguments around increased investment in health. Once political windows of opportunity have been identified, effective communication and flexibility to frame and fit narratives around investments in health according to budget holder priorities are key. An interviewee from Ireland covered a notable example of seizing the opportunity to obtain funding for health as described in Box 8.

7.3 Opportunities for making the case for funding for health range from the local to the international level

Opportunities for making the case for public investments in health range from the local all the way to the international level. Since the interviews that were conducted for this exercise were largely (but not always) focused on making the case for funding at the national level, the arguments, tools, data and enablers described above are mostly framed for the national context. However, the same principles apply to making a good budget case and successfully negotiating for health, no matter the level.

7.3.1 Regardless of the level of negotiation, the same principles of good negotiation practice and argument tend to be consistent

It is important that those advocating for health financing in any context use robust evidence (through data, tools, models and indicators) to steer budget holders to make good choices, and therefore to invest in health areas that will provide value for money. However, the success of negotiations will still depend on whether there is political will, whether the arguments for health have been framed with a compelling narrative, whether there are appropriate governance arrangements to facilitate good communication and engagement, and whether there is transparency, accountability, understanding and, ultimately, trust between decision makers.

Whether at the local, regional, national or international level, successfully obtaining additional funds for health will often depend on identifying windows of opportunity when they arise. It is important to understand the types of resources that exist, the objectives of the budget holders who are involved, and the contexts in which they are operating, so that budget narratives for health can be built and framed accordingly.

Box 8 **Capitalizing on windows of opportunity: a recent case from Ireland**

An interviewee from Ireland described a notable example of seizing an opportunity to obtain additional funding for health. With inflation and the cost of living recently increasing in the country, discussion began to emerge around potential government initiatives that could be funded and implemented to help the public deal with rising costs. The Department of Health thought creatively about how they might use this window of opportunity to fund their initiatives. Recognizing that a potential reform to eliminate hospital co-payments that had been on the table for several years could now be framed as a cost of living measure, they were able to seize the opportunity. They were successful and the measure was ultimately included in the cost of living package.

7.3.2 For EU Member States there are opportunities to access existing EU resources for health

There is a growing body of resources that can shed light on EU opportunities for increased funding for Member States. As part of the TSI project, workstream 2 undertook a tailored mapping exercise of existing EU resources for health, their uses, and possible combinations by focusing on three pilot cases (Mauer, Durvy & Panteli, 2024). This builds on an existing European Observatory policy brief which maps EU resources that can be used for health (Fahy, Mauer & Panteli, 2021). Combined with the material from this report, policy makers can take stock of the opportunities that exist and the tools, data and indicators they have (or can get access to) to begin to select the most effective and compelling arguments. Using these, they can frame proposals for health funding in a way which aligns health and funding priorities.

8. Conclusion

The mapping exercise and this resulting report are a resource to help health policy makers and advocates begin to navigate the complexities of building and supporting a case for additional financing for health. It provides a framework of the types of argument that can be used and examples of indicators and tools to support these. Furthermore, it highlights how these arguments are (or are not) actually used in practice to make the case for public investments in health. It identifies the factors which enable success – or whose absence limit it. It is intended as a starting point for stakeholders to identify potential ways to strengthen their investment cases for health. It is not a manual or a step-by-step instruction kit for building an investment case for health.

Ultimately, for budget cases for health to be successful, they should be framed with a narrative that meets the objectives and goals of those that they are being pitched to. As such, building each case for increased public investment in health will be a bespoke process that is particular to the context it is being designed for. This report can be used to help health decision makers and advocates consider different approaches to take and evidence to use in making the case for increased funding for health. These can then be selected, adapted and built on to fit their specific needs and the settings in which they are operating.

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